CalPERS Web Services, Forms, and Publications
Table of Contents

The information provided in this publication is for your convenience and reference as a general guide only and cannot be relied upon as an authoritative source for the law, practices, or policies of CalPERS. While CalPERS tries to include only accurate, timely and complete information in its publications, summaries, guidelines and other advisory printed materials, sometimes information provided in printed materials may be or become inaccurate, untimely, incomplete, unclear or misleading. In all instances, the law then in effect, not this publication, controls the application of the Public Employees' Retirement Law. It is the reader's responsibility to independently verify the accuracy of the information contained in this publication before engaging in a course of action.

CalPERS Web Services

CalPERS On-Line provides instant access to general CalPERS information for members, employers, and the public.

Look on the Internet for ***CalPERS On-Line*** at **www.calpers.ca.gov**. ***CalPERS On-Line*** highlights information about CalPERS retirement plans, health benefit programs, and pension fund investments. Agencies refer to the comprehensive "Employer Information" area to find the following information:

- ACES
- Actuarial Information
- CalPERS Retirement Calculation Information
- Circular Letters
- Employer Education
- Employer Forms and Publications
- Employer Rates
- Health Benefits Information
- Membership, Payroll & Compensation Information

The *Employer Information* section also provides information about how to contact CalPERS.

CalPERS strives to provide useful information to members, employers, and the public in a quick, easily accessible format through the Web site. ***CalPERS On-Line*** supplements the existing telephone and in-person services at our headquarters and regional offices.

If you have any comments or suggestions for the *Employer Information* section of the Web site, please e-mail CalPERS through the online *"Ask CalPERS"* service or call CalPERS Customer Contact Center at **888 CalPERS** (or **888**-225-7377).

CalPERS Employer eBulletin

CalPERS Employer eBulletins provide the latest news and information regarding Circular Letters, Board of Administration information, and other communications, tailored specifically for employers via email. Agency personnel (i.e., accounting and payroll staff, health benefits officers, city managers, etc.), administrators, and other interested parties can all benefit from this service by receiving CalPERS Employer eBulletins directly in their email box as soon as news is released. Each CalPERS Employer eBulletin comes in a plain text format for easy viewing and email retrieval and contains direct links to the actual employer information on the CalPERS Web site.

You can sign up for CalPERS Employer eBulletins on the CalPERS Web site at **www.calpers.ca.gov**.

Circular Letters

Circular Letters are issued to keep you informed of changes in policies and procedures. These letters provide important documentation to reference when working on CalPERS issues. Circular Letters are mailed to employers, but you can also receive an email informing you of the release of a new letter by subscribing to CalPERS Employer eBulletins. ***CalPERS On-Line*** has an archive of letters going back to 1996. You can search by date or key word to find the information you need.

Get Ready For my|CalPERS with PERT

See how my|CalPERS will provide employers the freedom to manage their own Health and Retirement Enrollment, Payroll Contributions, and Supplemental Income Plans.

Our Public Employer Readiness Team (PERT) is dedicated to helping employers learn how they will benefit from the transition to this new technology. Visit the PERT Web area at **www.calpers.ca.gov/pert** or email them with your questions at **PERT4U@calpers.ca.gov** for more information.

ORDERING FORMS AND PUBLICATIONS

Forms and publications are available for downloading from the CalPERS Web site, By following the instructions below:

- Access ***CalPERS On-Line*** at **www.calpers.ca.gov**
- Select the "For Employers" tab
- Select your employer type button
- Select "Next" at the bottom
- Select "Confirm"
- From the menu on the left, select "Forms & Publications Directory" hyperlink

If you need assistance, please call:
CalPERS Customer Contact Center
888 CalPERS (or **888**-225-7377)
(916) 795-3005 (Fax)

ORDERING FORMS AND PUBLICATIONS

CalPERS forms and publications are available for download from ***CalPERS On-Line*****.** They are also available in hardcopy. To order supplies in bulk, please use one of the following methods:

Mail to: (using letterhead from your agency)
CalPERS
Attn: Public Agency Requests
P.O. Box 942715
Sacramento, CA 94229-2715

Fax to:
CalPERS
Public Agency Requests
(916) 795-3281

Telephone:
Public Agency Requests
(916) 795-1493
8:30 am — 5:00 pm

E-mail:
Public_Agency_Requests@CalPERS.ca.gov

Please include your agency name, agency address, agency telephone number (with area code) and CalPERS employer code, for shipping purposes. Also include the form/ publication number, title, number of units ordered and unit of measure for each item ordered, with each request.

If you do not receive your order within 15 days of submitting your request, please contact the Public Agency Request Unit at (916) 795-1493.

SIZE OF ORDER

When ordering supplies, please limit your order to a six-month supply only. The system keeps a record of the supply needs of each agency. If an excess number of forms or publications are ordered, the Supply Section will reduce the order to the maximum allowed for your agency.

LIST OF CALPERS PUBLICATIONS

PUBLICATIONS

Your Benefits Your Future — School Benefits	PUB-2
Your Benefits Your Future — State Miscellaneous & Industrial Benefits	PUB 6
Your Benefits Your Future — State Safety Benefits	PUB 7
Your Benefits Your Future — Local Miscellaneous Benefits	PUB-8
Your Benefits Your Future — Local Safety Benefits	PUB-9
Your Benefits Your Future — National Guard Benefits	PUB-11
A Guide to Your Service Credit Purchase Options	PUB-12
Temporary Annuity	PUB-13
When You Change Retirement Systems	PUB-16
Retirement Option 4	PUB-18
CalPERS. When You Need Us. (Member)	PUB-24
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A Guide to Completing Your CalPERS Non-Member Service Retirement Election Application	PUB-44
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State Miscellaneous & Industrial Benefit Election Package	PUB-52
Changing Your Beneficiary or Monthly Benefit After Retirement	PUB-98

CalPERS Forms Referenced in Manual

The forms on the following pages are referenced in this edition of the CalPERS Public Agency Procedures Manual. Although these forms were current as of the printing of this Manual, forms are subject to revision. These forms are included only as examples. You may find copies of these forms on the CalPERS Web site, **www.calpers.ca.gov**, or by calling **888 CalPERS** (or **888**-225-7377).

Form Name	Form Number
Member Action Request	PERS-AESD-1
Report of Separation and Advance Payroll Information	PERS-BSD-194
Beneficiary Designation Form	PERS-BSD-241
Justification for Absence of Spouses or Registered Domestic Partner's Signature	PERS-BSD-800
Disability Retirement Election Application	PERS-BSD-369-D
Service Retirement Election Application	PERS-BSD-369-S
Birth Date Discrepancy	PERS-MEM-12
Request for Service Credit Cost Information – Service Prior to Membership, CETA & Fellowship Service	PERS-MSD-370
Request for Service Credit Cost Information – Leave of Absence	PERS-MSD-371
Request for Service Credit Cost Information – Layoff, Prior Service & Optional Member Service	PERS-MSD-372
Physical Requirements of Position/Occupational Title	PERS01 M0050 DMC
Employer Information for Disability Retirement	PERS01 M0052 DMC
Separation/Disposition of CalPERS Contributions	PERS-STD-687
Refund Election Form	PERS01 M0349 DMC

The below items, discussed at greater length in the Manual, can be found on the following pages:

Form Name	Form Number	Page
Member Action Request Form	PERS-AESD-1	45
Election of Optional Membership	PERS-AESD-59	49
Authorization for Contribution and/or Rate Adjustment	PERS-MEM-823a	65
Payroll Reporting Pre-List	PERS-AESD-625A	135
Report for Separation for Death — Request for Payroll Information	PERS-BSD-738	182
Member Acknowledgement Letter	PERS-BSD-451A	189
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Notice of Placement on Retirement Roll	PERS-BAS-62	192
Requested Employer Certification	PERS-BSD-200	193
Amended Employer Certification	PERS-BSD-200A	194

CalPERS
P.O. Box 942709
Sacramento, CA 94229-2709
Telephone (888) 225-7377
FAX (916) 795-3287
TDD (916) 795-3240

(Please PRINT or TYPE clearly)

INCOMPLETE OR IMPROPERLY COMPLETED FORMS MAY BE RETURNED TO YOU

Member Action Request

1 SOCIAL SECURITY NUMBER	2 Current Name (First, Middle, Last)	3 Daytime Phone Number
- -		(

4 Date of Birth	5 Gender	6 Former Name - For name changes only (First, Middle, Last)
MM DD YYYY	☐ Female ☐ Male ☐ Unknown	

7 Mailing Address:	8 Remarks (pertaining to CalPERS)
In Care of (if applicable):	
Street/P.O. Box:	
Additional Address Line:	9 Employer Name
City:	
State: CA ZIP Code: -	

10 Effective Date of Action	11 Subject to Section 20306	12 Employer Code	13 District Code (Schools only)	14 Hire Date
MM DD YYYY	☐ Yes ☐ No			MM DD YYYY

15 Type of Action (check all boxes that apply **for this Effective Date**; if none apply, indicate action needed in "Remarks" [#8] above):

A. ☐ Appointment/Membership	E. ☐ Military Leave	I. ☐ Alternate Retirement Plan (G.C. 20306)
B. ☐ Return from Leave	F. ☐ Worker's Comp Leave	J. ☐ Name Change
C. ☐ Separation, Permanent	G. ☐ Sabbatical Leave	K. ☐ Address Change
D. ☐ Separation, Temp (≧ 2 months)	H. ☐ Maternity/Paternity Leave	L. ☐ Coverage Group Change

16 Coverage Group	17 Job/Position Title	18 ½ @ 55 Formula
		Cont. Rate: %

19 ☐ - This person is an Optional Member (e.g., "Elective Officer," "Legislative Employee") who is electing membership.
(Please attach appropriate election form AESD-3, AESD-59, or AESD-229)

20 **BASIS FOR MEMBERSHIP QUALIFICATION:** (Optional informational field. Check appropriate box.)

- ☐ Full-Time for > 6 months
- ☐ Part-Time for ≧ 20 hours for 1 year or more
- ☐ Indeterminate; at least 20 hours a week for 1 year or more
- ☐ Has completed 1,000 hours or 125 days in fiscal year
- ☐ Person is already a PERS member

21 Form Completed By:

(Name & Title)

(Telephone Number) (Fax Number) (Date)

(Signature of Certifying Officer) (Date)

PERS-AESD-1 (02/2002)

Report of Separation and Advance Payroll Information

888 CalPERS (or 888-225-7377) • TTY for Speech and Hearing Impaired: (916) 795-3240

Employer: Please complete this form as soon as possible and return to CalPERS.

Section 1 — Employing Agency and Member Information

Your cooperation in immediately providing an advance estimate of the requested information is critical for us to make accurate payment at the earliest possible date.

Name of Employing Agency

This member has applied for disability retirement.

Name of Member (First Name, Middle Initial, Last Name) | Social Security Number

Requested Retirement Date (mm/dd/yyyy)

Section 2 — Effective Separation or Termination Dates

Last day on pay status will be upon expiration of accrued sick leave or compensated time off.

Separation Date (mm/dd/yyy) | Termination Date (mm/dd/yyyy) | Last Day on Pay Status (mm/dd/yyyy)

Leave of Absence With Compensation

Beginning Date (mm/dd/yyyy) | Ending Date (mm/dd/yyyy) | Type of Compensation

Explain the difference between the date of separation and last day on pay status, if any. _____

Section 3 — Unused Sick Leave at Time of Separation

Accumulated hours must be converted to **days** using the appropriate conversion factor applicable to each employee's individual classification or position. Calculate to three decimal places.

Balance of unused sick leave hours at time of separation: _____ (Hours) ÷ 8 = _____ (Days)

Section 4 — Certification of Employer

The above information is based on payroll information currently available.

Signature of Payroll Officer | Title

Date (mm/dd/yyyy) | ( ) Phone Number

Mail to: **CalPERS Benefit Services Division** • P.O. Box 942711, Sacramento, California 94229-2711

CalPERS

BENEFICIARY DESIGNATION

PERS-BSD-241 (Revised 12/04)

TO: CalPERS/ Benefit Services Division
P.O. Box 942711
Sacramento, CA 94229-2711
Fax:(916) 795-3933
Phone:(888) CalPERS (225-7377)

MEMBER'S FULL NAME (PLEASE PRINT)	SOCIAL SECURITY NUMBER	BIRTH DATE	TELEPHONE NUMBER

I understand that if I am married or in a registered domestic partnership but do not name my spouse or domestic partner as beneficiary, she/he may still be entitled to a community property share of my 'Lump Sum Contributions' or a share of any monthly allowance that may be payable. My 'Non-Spouse or Non-Partner' designated beneficiaries will receive the portion of my lump sum benefits, which are not payable to my spouse or domestic partner as his/her community property share. I further understand that if my death is determined to be "Industrial," special death benefits will be paid in the manner prescribed by law. If no percentage (%) is given, the applicable benefits will be paid SHARE AND SHARE ALIKE.

PRIMARY BENEFICIARIES

FIRST NAME	MIDDLE NAME	LAST NAME	%	RELATIONSHIP TO MEMBER	SOCIAL SECURITY NUMBER
ADDRESS (*Number and Street*)		*(City)*		*(State)*	*(Zip Code)*
FIRST NAME	MIDDLE NAME	LAST NAME	%	RELATIONSHIP TO MEMBER	SOCIAL SECURITY NUMBER
ADDRESS (*Number and Street*)		*(City)*		*(State)*	*(Zip Code)*
FIRST NAME	MIDDLE NAME	LAST NAME	%	RELATIONSHIP TO MEMBER	SOCIAL SECURITY NUMBER
ADDRESS (*Number and Street*)		*(City)*		*(State)*	*(Zip Code)*

In the event that I survive the person(s) named above, I hereby designate the following person(s) who survive me, as BENEFICIARIES. If no percentage (%) is given, benefits will be paid SHARE AND SHARE ALIKE.

SECONDARY BENEFICIARIES

FIRST NAME	MIDDLE NAME	LAST NAME	%	RELATIONSHIP TO MEMBER	SOCIAL SECURITY NUMBER
ADDRESS (*Number and Street*)		*(City)*		*(State)*	*(Zip Code)*
FIRST NAME	MIDDLE NAME	LAST NAME	%	RELATIONSHIP TO MEMBER	SOCIAL SECURITY NUMBER
ADDRESS (*Number and Street*)		*(City)*		*(State)*	*(Zip Code)*

Should I survive all of the persons named above, I understand that the benefits payable on account of my death will be paid to my statutory beneficiaries, or to such other beneficiary or beneficiaries that I may hereafter designate in writing to the Board of Administration, all in accordance with the applicable provisions of law.

BY THIS BENEFICIARY DESIGNATION, I HEREBY REVOKE ANY PREVIOUS DESIGNATION I HAVE FILED. I UNDERSTAND THAT MY MARRIAGE OR REGISTERED DOMESTIC PARTNERSHIP, DISSOLUTION OR ANNULMENT OF MY MARRIAGE OR DOMESTIC PARTNERSHIP, OR THE BIRTH OR ADOPTION OF A CHILD OR TERMINATION OF MEMBERSHIP SUBSEQUENT TO THE DATE I FILE THIS FORM WITH CALPERS, WILL AUTOMATICALLY VOID THIS DESIGNATION. HOWEVER, A DESIGNATION FILED AFTER THE INITIATION OF A DISSOLUTION/ANNULMENT OF MARRIAGE OR REGISTERED DOMESTIC PARTNERSHIP IS NOT REVOKED WHEN THE DISSOLUTION/ANNULMENT IS FINALIZED.

Signatures Required

Are you legally married or have a registered domestic partner? ☐ No ☐ Yes
If yes, your spouse or registered domestic partner must sign this form
If no, please indicate: ☐ Never married/or Never in Domestic Partnership ☐ Divorced/Annulled ☐ Widowed

IMPORTANT – *You must complete the BSD-800 on the reverse side of this form if you are married or have a registered domestic partnership but your spouse or domestic partner is unable to sign below.*

MEMBER SIGNATURE: _____ **Date:** _____

MEMBER ADDRESS: _____
(Number and Street) *(City)* *(State)* *(Zip Code)*

SPOUSAL/REGISTERED DOMESTIC PARTNER ACKNOWLEDGEMENT: ***By signing this beneficiary designation form, I acknowledge the information entered by my spouse/domestic partner.***

SPOUSE/DOMESTIC PARTNER SIGNATURE: _____

INFORMATION AND INSTRUCTIONS FOR CalPERS BENEFICIARY DESIGNATION FORM

If you die before you retire, the Public Employees' Retirement Law provides for payment of specific Death Benefits to your surviving beneficiaries. Please see your personnel officer for a description of the benefits. The benefits are payable to the following beneficiaries:

A. If you are a safety member and your death is job-related, or if you are not a safety member but you are fatally attacked while performing your official job duties, the Special Death Benefit may be payable. This benefit is payable by law to your surviving spouse/registered domestic partner (whether or not you were still living together at the time of your death) or, if none, to your unmarried children/step-children under age 22, whether or not you have filed a beneficiary designation.

B. If you are eligible for retirement or you are a State member with at least 20 years of State service credit, a monthly death benefit allowance may be payable. If you do not have a valid beneficiary designation on file, the benefits will be payable to your surviving spouse/registered domestic partner to whom you have been married to or in a partnership with for either one year or prior to the onset of the injury or illness that resulted in death. Or, if there is no eligible surviving spouse/registered domestic partner, the allowance will be payable to your unmarried minor children, if any.

   If you *do have* a valid beneficiary designation on file your spouse/registered domestic partner may still be entitled to a community property share of your lump sum contributions or monthly death benefit allowance. However, your non-spouse/non-domestic partner designated beneficiaries will receive the portion of your lump sum benefits which are not payable to your spouse/registered domestic partner as his/her community property share.

C. If A and B do not apply and *there is no* valid Beneficiary Designation on file at the time of death, the benefits will be payable to your survivors in the following order:

   1. Your surviving spouse/registered domestic partner (whether or not you were still living together at the time of your death); or, if none
   2. Natural and adopted children, including (in limited situations) a natural child adopted by another, share and share alike; or, if none,
   3. Parents, share and share alike; or if none,
   4. Brothers and sisters, share and share alike, or if none,
   5. Your estate (if probated, or subject to probate), or if not,
   6. Your trust (if one exists), or if not,
   7. Stepchildren, share and share alike, or, if none,
   8. Grandchildren, including step-grandchildren, share and share alike, or, if none,
   9. Nieces and nephews, share and share alike, or, if none,
   10. Great-grandchildren, share and share alike, or, if none,
   11. Cousins, share and share alike.

   If A and B do not apply and *there is* a valid Beneficiary Designation on file at the time of death, the benefits will be payable to the beneficiary(ies) you designate on the form. **However, if you are married or have a registered domestic partner at the time of death, your spouse/domestic partner may still be entitled to a community property share of your lump sum contributions.**

D. You may designate or change your beneficiaries at any time by completing another Beneficiary Designation form. You may name as beneficiary any person or persons, a corporation or your estate. Payment will be made to your estate only if probated. You may designate a trust as your beneficiary; however, you must provide the name of the trust, the date of the trust, and the name and address where the trust is filed. It is not necessary to provide the name of the trustee. Reminder: **If you are married or in a domestic partnership at the time of your death and you do not name your spouse/domestic partner as beneficiary, he/she may still be entitled to a community property share of your lump sum contributions or a share of any monthly allowance that may be payable.**

E. Your Beneficiary Designation will be revoked automatically, and benefits will be payable to the closest survivor listed in section C, if any of the following events occur after your designation form is received by CalPERS:

   1. Marriage/Registration of Domestic Partnership; or
   2. Dissolution or annulment of your marriage/domestic partnership. However, a designation filed after the initiation of a dissolution/annulment of marriage or domestic partnership is <u>*NOT*</u> revoked when the dissolution/annulment is finalized; or
   3. Birth or adoption of a child; or
   4. Termination of membership that results in a refund of your contributions.

INSTRUCTIONS (See Reverse Side of This Page)

INSTRUCTIONS

1. Print clearly with ball point pen or type all information requested. If you make an error, make the necessary correction by lining through the error and initialing the change. *No erasures or correction fluid will be accepted*.

2. Enter on the form the full name of your beneficiaries, relationship, social security number (if known), and the complete address for each. (If the form does not provide enough space, you may attach additional sheets provided you indicate whether you are designating "primary" or "secondary" beneficiaries. You must sign, date, and write your social security number at the top of each additional sheet.)

3. If a (%) is entered make sure the total equals 100%.

4. Your spouse/registered domestic partner must sign the form to acknowledge the names of the beneficiaries you are designating. **IMPORTANT:** If you are unable to obtain your spouse's/domestic partner's signature, you MUST complete the BSD-800, "Justification for Absence of Spouse or Domestic Partner's Signature" form, on the reverse side of the designation form or your designation form may be rejected.

5. Enter the date you signed the form and your current mailing address.

6. Mail the completed form to the Public Employees' Retirement System at the address shown, or you may fax it to (916) 795-3933.

7. After CalPERS receives and reviews the form a confirmation letter will be mailed to you within 6 weeks. If the form is not acceptable a new form will be mailed to you to complete.

IMPORTANT INFORMATION

The Information Practices Act of 1977 and the Federal Privacy Act require the California Public Employees' Retirement System to provide the following information to individuals who are asked to supply information. The information requested is collected pursuant to the Government Code Sections (20000, et seq.) and will be used for administration of the Board's duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Failure to supply all of the requested information may result in the System being unable to perform its functions regarding your status. Portions of this information may be transferred to: state and public agency employers, California State Attorney General, Office of the State Controller, Teale Data Center, Franchise Tax Board, Internal Revenue Service, Workers' Compensation Appeals Board, State Compensation Insurance Fund, County District Attorneys, Social Security Administration, beneficiaries of deceased members, physicians, insurance carriers, and various vendors who prepare microfiche/microfilm for CalPERS. Disclosure to these parties is done in strict accordance with current statutes regarding confidentiality.

You have the right to review your membership files maintained by the California Public Employees' Retirement System. For questions concerning your rights under the Information Practices Act of 1977, please contact the Information Practices Act Coordinator, CalPERS, P.O. Box 942702, Sacramento, CA 94229

Benefit Services Division
P.O. Box 942711
Sacramento, CA 94229-2711
(888) Cal-PERS (225-7377)
TDD - (916) 795-3240; FAX (916) 795-3933

JUSTIFICATION FOR ABSENCE OF SPOUSE OR REGISTERED DOMESTIC PARTNER'S SIGNATURE

Pursuant to Government Code Section 21261, the member's current spouse or registered domestic partner must be made aware of the selection of benefits or change in beneficiary made by the member. The spouse or domestic partner of a CalPERS member must acknowledge the submission of a request for refund of contributions; election of retirement optional settlement; and designation of beneficiary for Pre-retirement Death Benefits.

If a spouse or domestic partner's signature does not appear on one of the above-mentioned documents, the following information **MUST** be completed by the member and submitted with the application/form.

MEMBER'S NAME (TYPED OR PRINTED)	SOCIAL SECURITY NUMBER
APPLICATION SUBMITTED	
BENEFICIARY DESIGNATION (PERS-BSD-241)	

Select either 1 or 2 and indicate specifics:

1. ☐ By checking this box, I indicate that I am not legally married or in a registered domestic partnership because:

   ☐ Never married or never in registered domestic partnership.

   ☐ Divorced/marriage annulled or domestic partnership terminated. _____
   Date (mm/dd/yyyy)

   ☐ Widowed. _____
   Date (mm/dd/yyyy)

2. ☐ By checking this box,I indicate that I am married or have a domestic partner, but my spouse or domestic partner did not sign this form because:

   ☐ I do not know and have taken all reasonable steps to determine the whereabouts of my spouse or domestic partner, **OR**,

   ☐ My spouse or domestic partner has been advised of the application and has refused to sign the written acknowledgement; **OR**

   ☐ My spouse or domestic partner is incapable of executing the acknowledgement because of an incapacitating mental or physical condition; **OR**,

   ☐ My spouse or domestic partner has no identifiable community property interest in the benefit, **OR**,

   ☐ My spouse or domestic partner and I have executed a marriage settlement or partnership agreement that makes the community property law inapplicable to the marriage or partnership.

I certify under penalty of perjury that the foregoing information is true and correct.

MEMBER'S SIGNATURE	**DATE SIGNED**

PERS-BSD-800 (Revised 12/04)

Disability Retirement Election Application

888 CalPERS (or 888-225-7377) • TTY for Speech and Hearing Impaired: (916) 795-3240

Employer Information

☐ Check if this is an employer-originated application.
Employer must fill out and sign Section 12 on the last page of this application.

Application Type

☐ Disability Retirement
☐ Service Pending Disability Retirement
☐ Industrial Disablility Retirement
☐ Service Pending Industrial Disability Retirement

Section 1 — Information About You

Please provide your name as it appears on the Social Security card.

Please display all dates in this order: month/day/year.

Name of Member (First Name, Middle Initial, Last Name) | Social Security Number

Address

City | State | ZIP | Country

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | ( ) Home Phone | ( ) Work Phone

Section 2 — Retirement Information

Please do not abbreviate your employer or position.

Do not list Social Security, military or railroad retirement as a California public retirement system.

Retirement Date (mm/dd/yyyy)

Employer | Position Title

Do you have any final compensation period higher than the last consecutive 12 or 36 months?
☐ No ☐ Yes, from _____ (Beginning Date (mm/dd/yyyy)) to _____ (Ending Date (mm/dd/yyyy)).

Are you a member of a California public retirement system other than CalPERS? ☐ No ☐ Yes, provide:

Name of System

Date of Retirement (mm/dd/yyyy) | Beginning Service Credit Date (mm/dd/yyyy) | Ending Service Credit Date (mm/dd/yyyy)

Section 3 — Workers' Compensation Information

Local safety members should not complete Sections 3 & 4.

Workers' Compensation Carrier

Name of Adjuster | ( ) Phone Number

Address

City | State | ZIP

Claim Number(s) Relating to Alleged Disability | Date of Injury (mm/dd/yyyy)

Put your name and Social Security number at the top of every page.

Your Name _____ Social Security Number _____

Section 4

Disability Information

Please complete all the questions below. If you need additional space, attach separate sheets and be sure to include your name and Social Security number on all sheets.

What is your specific disability; when and how did it occur?

What is the complete name and address of your treating physician(s)?

Name of Treating Physician _____ Medical Record Number _____

Address _____

City _____ State _____ ZIP _____ Phone Number ( ) _____

What are your limitations/preclusions due to your injury or illness?

How has your injury or illness affected your ability to perform your job?

Are you currently working in any capacity (full-time, part-time, or modified work)? If yes, please explain.

Other information you would like to provide.

Did a third party cause your injury? ☐ No ☐ Yes (If yes, CalPERS has a potential "right of subrogation.")

Put your name and Social Security number at the top of every page.

Your Name _____ Social Security Number _____

Section 5

Select Your Retirement Payment Option and Beneficiary

Select **only one** payment option: Option 1, Option 2, Option 2W, Option 3, Option 3W, the Unmodified Allowance Option, or one of the Option 4 types.

By filling out this section, you are electing your Retirement Payment Option and designating your beneficiary. Once you select a payment option, you cannot change to another option. Along with your option selection, you must complete at least one of the beneficiary designations in Sections 5a-5d. If you choose the Unmodified Allowance Option, you do not need to specify a beneficiary. Please refer to the detailed instructions in this publication for more information.

☐ **Option 1** - To complete this option choice, you must also fill out Section 5d, *Balance of Contributions Beneficiary(ies).*

☐ **Option 2** - To complete this option choice, you must also fill out Section 5a, *Individual Lifetime Beneficiary.*

☐ **Option 2W** - To complete this option choice, you must also fill out Section 5a, *Individual Lifetime Beneficiary.*

☐ **Option 3** - To complete this option choice, you must also fill out Section 5a, *Individual Lifetime Beneficiary.*

☐ **Option 3W** - To complete this option choice, you must also fill out Section 5a, *Individual Lifetime Beneficiary.*

☐ **Unmodified Allowance Option** - If you select this option there is no return of your member contributions and no monthly benefits payable upon your death - except the Survivor Continuance benefit, if applicable. There is no beneficiary designation for this option.

These options apply to Option 4 **Individual Lifetime Beneficiary** only.

☐ **Option 4, Individual Lifetime Beneficiary** - If you select this option, you must also select one of the following Individual Lifetime Beneficiary options below.

- ☐ **Option 2W & Option 1** Combined - To complete this option choice, you must also fill out Section 5a *Individual Lifetime Beneficiary* and Section 5d *Balance of Contributions Beneficiary(ies).*
- ☐ **Option 3W & Option 1 Combined** - To complete this option choice, you must also fill out Section 5a *Individual Lifetime Beneficiary* and Section 5d *Balance of Contributions Beneficiary(ies).*
- ☐ **Specific Dollar Amount to Beneficiary** $_____ (Dollars) - To complete this option choice, you must also fill out Section 5a *Individual Lifetime Beneficiary*
- ☐ **Specific Percentage to Beneficiary** _____ (Percent) % - To complete this option choice, you must also fill out Section 5a *Individual Lifetime Beneficiary*
- ☐ **Reduced Allowance for Fixed Period of Time** _____ (Percent or Dollars) **through** _____ (Date (mm/yyyy)).
- ☐ **Reduced Allowance upon death of retiree or beneficiary:** $_____ (Dollars) **reduction amount**

  If you are naming a beneficiary under this option, you must also fill out Section 5a, *Individual Lifetime Beneficiary.*

This option applies to Option 4 **Multiple Lifetime Beneficiaries** only.

☐ **Option 4, Multiple Lifetime Beneficiaries** - To complete this option choice, you must also fill out Section 5b *Option 4 Multiple Lifetime Beneficiaries.*

These options apply to Option 4, **Court Ordered Community Property** only.

☐ **Option 4, Court Ordered Community Property** - If you select this option, you must also complete Section 5c, *Court Ordered C.P. Beneficiary* and select one of the following Court Ordered Option 4 Community Property options.

- ☐ **Option 4/Unmodified** - There is no additional beneficiary designation for this option.
- ☐ **Option 4/1** - To complete this option choice, you must also fill out Section 5d, *Balance of Contributions Beneficiary(ies).*
- ☐ **Option 4/2W** - To complete this option, you must also fill out Section 5a, *Individual Lifetime Beneficiary.*
- ☐ **Option 4/3W** - To complete this option, you must also fill out Section 5a, *Individual Lifetime Beneficiary.*

Put your name and Social Security number at the top of every page.

Your Name | Social Security Number

Section 5a

Option 2, 2W, 3, 3W or 4 individual Lifetime Beneficiary

Designate one beneficiary and provide all of that person's information including full name.

Complete this section only if you chose either Option 2, 2W, 3, 3W or Option 4 Individual Lifetime Beneficiary or Option 4/2W or 4/3W Court Ordered Community Property.

Name (First Name, Middle Initial, Last Name) | Social Security Number

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You

Address

City | State | ZIP | Country

Section 5b

Option 4 Multiple Lifetime Beneficiaries

If you want your beneficiaries to receive an equal share of your benefits, do **not** specify a dollar or percentage of benefit.

Complete this section **only** if you selected **Option 4 Multiple Lifetime Beneficiaries.**

Name (First Name, Middle Initial, Last Name) | Social Security Number

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You | Dollar/Percent of Benefit

Address

City | State | ZIP | Country

Name (First Name, Middle Initial, Last Name) | Social Security Number

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You | Dollar/Percent of Benefit

Address

City | State | ZIP | Country

Name (First Name, Middle Initial, Last Name) | Social Security Number

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You | Dollar/Percent of Benefit

Address

City | State | ZIP | Country

Section 5c

Court Ordered Option 4 Community Property Beneficiary

List **only** the Option 4 beneficiary that is required by your court order.

Complete this section **only** if you selected **Option 4 Court Ordered Community Property.**

Name (First Name, Middle Initial, Last Name) | Social Security Number

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You

Address

City | State | ZIP | Country

Put your name and Social Security number at the top of every page.

Your Name | Social Security Number

Section 5d

Designate up to three beneficiaries here. If you want to designate more than three beneficiaries. See page 23 for information on completing the ***Lump Sum Beneficiary Designation*** form.

Option 1 Balance of Contributions Beneficiary(ies)

Complete this section only if you selected **Option 1, Option 4-2W/1** or **3W/1 combined.** You may change this beneficiary(ies) at any time. This designation automatically revokes when there is a change in your marital status, domestic partnership status, or when there is a birth or adoption of a child. Please refer to the detailed instructions in this publication for more information.

Name (First Name, Middle Initial, Last Name) | Social Security Number

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You

Address

City | State | ZIP | Country

Name (First Name, Middle Initial, Last Name) | Social Security Number

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You

Address

City | State | ZIP | Country

Name (First Name, Middle Initial, Last Name) | Social Security Number

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You

Address

City | State | ZIP | Country

Section 6

All Applicants must complete this section.

Designate your beneficiary to receive your lump sum Retired Death Benefit.

Retired Death Benefit

This section designates the person who will receive your lump sum Retired Death Benefit. You may change this beneficiary(ies) at any time. This designation automatically revokes when there is a change in your marital status, domestic partnership status, or when there is a birth or adoption of a child. Please refer to the detailed instructions in this publication for more information.

Name (First Name, Middle Initial, Last Name) | Social Security Number

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You

Address

City | State | ZIP | Country

Section 6 continues on page 6

Put your name and Social Security number at the top of every page.

Your Name | Social Security Number

Section 6, continued — Retired Death Benefit

All Applicants must complete this section.

Designate your beneficiary to receive your lump sum Retired Death Benefit.

Name (First Name, Middle Initial, Last Name) | Social Security Number

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You

Address

City | State | ZIP | Country

Name (First Name, Middle Initial, Last Name) | Social Security Number

Birthdate (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You

Address

City | State | ZIP | Country

Section 7 — Survivor Continuance

Please answer all five questions and complete the information in each section where you answered "Yes."

Please refer to the detailed instructions in this publication for more information.

1. Will you be married on or before your disability retirement date? ☐ No ☐ Yes, provide:

Name of Spouse (First Name, Middle Initial, Last Name) | Social Security Number

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Date of Marriage

2. Will you be registered with the California Secretary of State as being in a domestic partnership on or before your disability retirement date? ☐ No ☐ Yes, provide:

Name of Domestic Partner (First Name, Middle Initial, Last Name) | Social Security Number

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Date of Registered Partnership (mm/dd/yyy)

3. Do you have any natural or adopted children under age 18 who have never been married? ☐ No ☐ Yes, provide:

Name of Child (First Name, Middle Initial, Last Name) | Social Security Number | Birth Date (mm/dd/yyyy)

Name of Child (First Name, Middle Initial, Last Name) | Social Security Number | Birth Date (mm/dd/yyyy)

4. Do you have any children who have never been married and were disabled prior to their 18th birthday and who are still disabled? ☐ No ☐ Yes, provide:

Name of Child (First Name, Middle Initial, Last Name) | Social Security Number | Birth Date (mm/dd/yyyy)

Name of Child (First Name, Middle Initial, Last Name) | Social Security Number | Birth Date (mm/dd/yyyy)

5. Are your parents dependent upon you for one-half of their support? ☐ No ☐ Yes, provide:

Name of Parent (First Name, Middle Initial, Last Name) | Social Security Number | Birth Date (mm/dd/yyyy)

Name of Parent (First Name, Middle Initial, Last Name) | Social Security Number | Birth Date (mm/dd/yyyy)

Put your name and Social Security number at the top of every page.

Your Name _____ Social Security Number _____

Section 8 Last Day on Payroll

Please enter the last day you received compensation. _____
Last Day on Payroll (mm/dd/yyyy)

Section 9 Employer Certification (For service pending applications only)

Have your employer complete this section.

Please refer to the detailed instructions in this publication for more information.

Employee's Last Day on Payroll (mm/dd/yyyy) _____ Employee's Separation Date (mm/dd/yyyy) _____

Do not detach from application.

Balance of unused sick leave hours on employee's date of separation _____ Hours ÷ 8 = _____ Days

Balance of educational leave hours on employee's date of separation _____ Hours ÷ 8 = _____ Days

This certification is not required if you were separated from employment more than four months ago.

By signing below, you hereby certify, under the penalty of perjury, that the above information is true, complete, and correct to the best of your knowledge. Any changes to this information must be submitted on an ***Amended Employer Certification*** form.

Signature of Employer _____ Print Name (First Name, Middle Initial, Last Name) _____

Position Title of Employer _____ Phone Number of Employer ( ) _____ Date (mm/dd/yyyy) _____

Section 10 Tax Withholding Election

Do not complete for industrial disabilty retirement.

Federal Income Tax information. Please refer to the detailed instructions in this publication for more information.

Please choose one only.

- ☐ Do not withhold federal income tax.
- ☐ Withhold federal income tax in the amount of $_____ Dollars per month.
- ☐ Withhold federal income tax based on the tax tables for:
  - ☐ **A married individual with _____ Number tax withholding exemptions.**
  - ☐ **A single individual with _____ Number tax withholding exemptions.**

  In addition to the amount withheld based on the tax tables, withhold $_____ Dollars per month.

State withholding is optional for out-of-state residents.

State Income Tax information. Please refer to the detailed instructions in this publication for more information.

- ☐ Do not withhold State of California income tax.
- ☐ Withhold State of California income tax in the amount of $_____ Dollars per month.
- ☐ Withhold State of California income tax based on the tax tables for:
  - ☐ **A married individual with _____ Number tax withholding exemptions.**
  - ☐ **A single individual with _____ Number tax withholding exemptions.**

  In addition to the amount withheld based on the tax tables, withhold $_____ Dollars per month.
- ☐ Withhold State of California income tax in the amount of 10 percent of the federal income tax withholding amount.

Put your name and Social Security number at the top of every page.

Your Name _____ Social Security Number _____

Section 11

This section must be completed or your application will be returned.

If your spouse's or domestic partner's signature is not available, See instructions in this booklet on completing the Justification for Absence of Signature form. Your signature and your spouse's or domestic partner's signature must be notarized by a notary public or witnessed by a CalPERS representative.

Member Signature and Notary

I certify, under the penalty of perjury, that the information submitted hereon is true and correct to the best of my knowledge. I understand to cancel this application or to change the elected option or beneficiary I must notify CalPERS before the mailing of my first full monthly retirement allowance check.

I understand that if I am married or in a registered domestic partnership, but do not name my spouse or partner as beneficiary, they may still be entitled to a community property share of the Option 1 lump sum return of contributions benefit **or** a share of the monthly option death benefit allowance. Their community property interest is 50% of the benefit based on the contributions or service credit earned for the period of CalPERS service during which we were married or in a registered partnership. My non-spouse or non-partner designated beneficiary will receive the portion of the lump sum Option 1 benefit or monthly option allowance that is not payable to my spouse or domestic partner. I understand that my spouse or domestic partner will have the right to disclaim entitlement to their community property interest in the death benefit at the time the benefit becomes payable, if they so desire.

More detailed information on this section is available in this publication.

Are you legally married or do you have a legal domestic partner? ☐ Yes ☐ No

If yes, your spouse or domestic partner must sign this election.

If no, please indicate: ☐ Never Married/or in Partnership ☐ Divorced/Annulled ☐ Widowed Or Termination of Domestic Partnership

Your Signature _____ Date (mm/dd/yyyy) _____

Your Spouse's or Domestic Partner's Signature _____ Date (mm/dd/yyyy) _____

State of California, County of _____

On _____ (Date) before me, _____ (Name of Notary/Witness)

personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument. I certify under **Penalty of Perjury** under the laws of the State of California that the foregoing paragraph is true and correct.

Notary Seal

Witness my hand and official seal **or** authorized CalPERS representative signature.

Signature of Notary or CalPERS Representative _____ Position Title _____ Date (mm/dd/yyyy) _____

Print Name _____ CalPERS Office (if applicable) _____

Section 12

To be completed if the employer is submitting the application on behalf of the member.

Employer-Originated Application

Signature of Employer _____

Print Name of Employer _____

Position Title of Employer _____ ( ) Phone Number _____ Date (mm/dd/yyyy) _____

Mail to: **CalPERS Benefit Services Division** • P.O. Box 942711, Sacramento, California 94229-2711

Service Retirement Election Application

(888) CalPERS (or 888-225-7377) • TTY for Speech and Hearing Impaired: (916) 795-3240

Please do not mail or deliver your application to CalPERS more than 90 days before your retirement date.

Section 1 — Information About You

Please provide your name as it appears on your Social Security card.

Name (First Name, Middle Initial, Last Name) _____ Social Security Number _____

Address _____

City _____ State _____ ZIP _____ Country _____

Please display all dates in this order: month/day/year.

Birth Date (mm/dd/yyyy) _____ ☐ Male ☐ Female Gender _____ Home Phone ( ) _____ Work Phone ( ) _____

Section 2 — Information About Your Retirement

Please do not abbreviate your employer or position.

Please refer to the detailed instructions in this booklet.

Retirement Date (mm/dd/yyyy) _____

Employer _____ Position Title _____

The Temporary Annuity benefit for which you are eligible is based on your CalPERS membership date.

Temporary Annuity - If you select this benefit, you must also fill out Section 3d, Option 1 Balance of Contributions and/or Temporary Annuity Balance beneficiary(ies).

To provide for an additional Temporary Annuity Allowance, you elect to reduce your monthly allowance for life. ☐ No ☐ Yes

If you first became a member on January 1, 2002, or later, you elect to receive Temporary Annuity until age _____ (62 to 70) in the amount of $_____ Dollars.

The amount of your Temporary Annuity cannot exceed the estimated amount of your Social Security benefit at the age designated in this election.

..... or .....

If you first became a member prior to January 1, 2002, you elect to receive Temporary Annuity until age _____ (59½ or whole age 60 to 68) in the amount of $_____ Dollars per month.

Final Compensation Period

Do you have any final compensation period higher than the last consecutive 12 or 36 months?

☐ No ☐ Yes, from _____ Beginning Date (mm/dd/yyyy) to _____ Ending Date (mm/dd/yyyy).

Do not list Social Security, military or railroad retirement as a California public retirement system.

Other California Public Retirement Systems

Are you a member of a California public retirement system other than CalPERS? ☐ No ☐ Yes, provide:

Name of System _____

Retirement Date (mm/dd/yyyy) _____ Beginning Service Credit Date (mm/dd/yyyy) _____ Ending Service Credit Date (mm/dd/yyyy) _____

Put your name and Social Security number at the top of every page

Your Name _____ Social Security Number _____

Section 3 — Select Your Retirement Payment Option and Beneficiary

By filling out this section, you are electing your Retirement Payment Option and designating your beneficiary. Once you select a payment option, you cannot change to another option. Along with your option selection, you must complete at least one of the beneficiary designations in Sections 3a-3d. If you choose the Unmodified Allowance Option, you do not need to specify a beneficiary. Please refer to the detailed instructions in this booklet for more information.

Select **only one** payment option: Option 1, Option 2, Option 2W, Option 3, Option 3W, the Unmodified Allowance Option, or one of the Option 4 types.

☐ **Option 1** - To complete this option choice, you must also fill out Section 3d, *Balance of Contributions Beneficiary.*

☐ **Option 2** - To complete this option choice, you must also fill out Section 3a, *Individual Lifetime Beneficiary.*

☐ **Option 2W** - To complete this option choice, you must also fill out Section 3a, *Individual Lifetime Beneficiary.*

☐ **Option 3** - To complete this option choice, you must also fill out Section 3a, *Individual Lifetime Beneficiary.*

☐ **Option 3W** - To complete this option choice, you must also fill out Section 3a, *Individual Lifetime Beneficiary.*

☐ **Unmodified Allowance Option** - If you select this option there is no return of your member contributions and no monthly benefits payable upon your death - except the Survivor Continuance Benefit, if applicable. There is no beneficiary designation for this option.

☐ **Option 4, Individual Lifetime Beneficiary** - If you select this option, **you must also select one of the following** Individual Lifetime Beneficiary options below.

These options apply to Option 4 **Individual Lifetime Beneficiary** only.

- ☐ **Option 2W & Option 1 Combined** - To complete this option choice, you must also fill out Section 3a *Individual Lifetime Beneficiary* and Section 3d *Balance of Contributions Beneficiary.*
- ☐ **Option 3W & Option 1 Combined** - To complete this option choice, you must also fill out Section 3a *Individual Lifetime Beneficiary* and Section 3d *Balance of Contributions Beneficiary.*
- ☐ **Specific Dollar Amount to Beneficiary** $ _____ (Dollars) - To complete this option choice, you must also fill out Section 3a *Individual Lifetime Beneficiary*
- ☐ **Specific Percentage to Beneficiary** _____ (Percent) % - To complete this option choice, you must also fill out Section 3a *Individual Lifetime Beneficiary*
- ☐ **Reduced Allowance for Fixed Period of Time** _____ (Percent or Dollars) **through** _____ (Date (month/year)).
- ☐ **Reduced Allowance upon death of retiree or beneficiary:** $ _____ (Dollars) **reduction amount**

  If you are naming a beneficiary under this option, you must also fill out Section 3a, *Individual Lifetime Beneficiary.*

This option applies to Option 4 **Multiple Lifetime Beneficiaries** only.

☐ **Option 4, Multiple Lifetime Beneficiaries** - To complete this option choice, you must also fill out Section 3b *Multiple Lifetime Beneficiaries.*

These options apply to Option 4, **Court Ordered Community Property** only.

☐ **Option 4, Court Ordered Community Property** - If you select this option, you must also complete section 3c, *Court Ordered C.P. Beneficiary* and select one of the following Court Ordered Community Property options.

- ☐ **Option 4/Unmodified** - There is no additional beneficiary designation for this option.
- ☐ **Option 4/1** - To complete this option choice, you must also fill out Section 3d, *Balance of Contributions Beneficiary.*
- ☐ **Option 4/2W** - To complete this option, you must also fill out Section 3a, *Individual Lifetime Beneficiary.*
- ☐ **Option 4/3W** - To complete this option, you must also fill out Section 3a, *Individual Lifetime Beneficiary.*

Put your name and Social Security number at the top of every page

Your Name | Social Security Number

Section 3a — Option 2, 2W, 3, 3W or 4 Individual Lifetime Beneficiary

Designate one beneficiary and provide all of that person's information including full name.

Complete this section only if you chose either Option 2, 2W, 3, 3W or Option 4 Individual Lifetime Beneficiary or Option 4/2W or 4/3W Court Ordered Community Property.

Name (First Name, Middle Initial, Last Name) | Social Security Number

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You

Address

City | State | ZIP | Country

Section 3b — Option 4 Multiple Lifetime Beneficiaries

If you want your beneficiaries to receive an equal share of your benefits, do **not** specify a dollar or percentage of benefit.

Complete this section **only** if you selected **Option 4 Multiple Lifetime Beneficiaries.**

Name (First Name, Middle Initial, Last Name) | Social Security Number

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You | Dollar/Percent of Benefit

Address

City | State | ZIP | Country

Name (First Name, Middle Initial, Last Name) | Social Security Number

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You | Dollar/Percent of Benefit

Address

City | State | ZIP | Country

Name (First Name, Middle Initial, Last Name) | Social Security Number

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You | Dollar/Percent of Benefit

Address

City | State | ZIP | Country

Section 3c — Court Ordered Option 4 Community Property Beneficiary

List **only** the Option 4 beneficiary that is required by your court order.

Complete this section **only** if you selected **Option 4 Court Ordered Community Property.**

Name (First Name, Middle Initial, Last Name) | Social Security Number

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You

Address

City | State | ZIP | Country

Put your name and Social Security number at the top of every page

Your Name | Social Security Number

Section 3d

Designate up to 3 beneficiaries here. If you want to designate more than 3 beneficiaries or name different beneficiaries for the Option 1 balance and the Temporary Annuity balance, see information in this booklet on completing the Lump Sum Beneficiary Designation form.

Option 1 Balance of Contributions and/or Temporary Annuity Balance Beneficiary(ies)

Complete this section only if you selected **Option 1, Option 4-2W/1** or **3W/1 combined** or the **Temporary Annuity** allowance. You may change this beneficiary(ies) at any time. This designation automatically revokes when there is a change in your marital status, domestic partnership status, or when there is a birth or adoption of a child. Please refer to the detailed instructions in this booklet for more information.

Name (First Name, Middle Initial, Last Name) | Social Security Number

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You

Address

City | State | ZIP | Country

Name (First Name, Middle Initial, Last Name) | Social Security Number

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You

Address

City | State | ZIP | Country

Name (First Name, Middle Initial, Last Name) | Social Security Number

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You

Address

City | State | ZIP | Country

Section 4

All Applicants must complete this section.

Designate your beneficiary to receive your Lump-Sum Retired Death Benefit.

Retired Death Benefit

This section designates the person who will receive your Lump-Sum Retired Death Benefit. You may change this beneficiary(ies) at any time. This designation automatically revokes when there is a change in your marital status, domestic partnership status, or when there is a birth or adoption of a child. Please refer to the detailed instructions in this booklet for more information.

Name (First Name, Middle Initial, Last Name) | Social Security Number

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You

Address

City | State | ZIP | Country

Name (First Name, Middle Initial, Last Name) | Social Security Number

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You

Address

City | State | ZIP | Country

Section 4 continues on page 5

Put your name and Social Security number at the top of every page

Your Name | Social Security Number

Section 4, continued — Retired Death Benefit, continued

All Applicants must complete this section.

Designate your beneficiary to receive your Lump-Sum Retired Death Benefit.

Name (First Name, Middle Initial, Last Name) | Social Security Number

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Relationship to You

Address

City | State | ZIP | Country

Section 5 — Survivor Continuance

Please answer all five questions and complete the information in each section where you answered "yes".

Please refer to the detailed instructions in this booklet for more information.

1. Will you be married on and at least one year prior to your retirement date? ☐ No ☐ Yes, provide:

Name of Spouse (First Name, Middle Initial, Last Name) | Social Security Number

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Date of Marriage

2. Will you be registered with the California Secretary of State as being in a domestic partnership on and at least one year prior to your retirement date? ☐ No ☐ Yes, provide:

Name of Domestic Partner (First Name, Middle Initial, Last Name) | Social Security Number

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female Gender | Date of Registered Partnership (mm/dd/yyyy)

3. Do you have any natural or adopted unmarried children under age 18? ☐ No ☐ Yes, provide:

Name of Child (First Name, Middle Initial, Last Name) | Social Security Number | Birth Date (mm/dd/yyyy)

Name of Child (First Name, Middle Initial, Last Name) | Social Security Number | Birth Date (mm/dd/yyyy)

4. Do you have any unmarried children who were disabled prior to their 18th birthday and who are still disabled? ☐ No ☐ Yes, provide:

Name of Child (First Name, Middle Initial, Last Name) | Social Security Number | Birth Date (mm/dd/yyyy)

Name of Child (First Name, Middle Initial, Last Name) | Social Security Number | Birth Date (mm/dd/yyyy)

5. Are your parents dependent upon you for one-half of their support? ☐ No ☐ Yes, provide:

Name of Parent (First Name, Middle Initial, Last Name) | Social Security Number | Birth Date (mm/dd/yyyy)

Name of Parent (First Name, Middle Initial, Last Name) | Social Security Number | Birth Date (mm/dd/yyyy)

Section 6 — Last Day on Payroll

Please enter the last day you received compensation.

(mm/dd/yyyy)

Put your name and Social Security number at the top of every page

Your Name _____ Social Security Number _____

Section 7 Employer Certification

Have your employer complete this section.

Please refer to the detailed instructions in this booklet for more information.

Employee's Last Day on Payroll (mm/dd/yyyy) _____ Employee's Separation Date (mm/dd/yyyy) _____

Do not detach from application.

Balance of unused sick leave hours on employee's date of separation _____ Hours ÷ 8 = _____ Days

Balance of educational leave hours on employee's date of separation _____ Hours ÷ 8 = _____ Days

This certification is not required if you are or were separated from employment for more than four months before your retirement date.

By signing below, you hereby certify, under the penalty of perjury, that the above information is true, complete, and correct to the best of your knowledge. Any changes to this information must be submitted on an Amended Employer Certification form.

Signature of Employer _____ Print Name (First Name, Middle Initial, Last Name) _____

Position Title of Employer _____ Phone Number of Employer ( ) _____ Date (mm/dd/yyyy) _____

Section 8 Tax Withholding Election

Please choose one only.

Federal Income Tax information. Please refer to the detailed instructions in this booklet for more information.

- ☐ Do not withhold federal income tax.
- ☐ Withhold federal income tax in the amount of $ _____ Dollars per month.
- ☐ Withhold federal income tax based on the tax tables for:
  - ☐ A married individual with _____ Number tax withholding exemptions.
  - ☐ A single individual with _____ Number tax withholding exemptions.

  In addition to the amount withheld based on the tax tables, withhold $ _____ Dollars per month.

Please choose one only.

State Income Tax information. Please refer to the detailed instructions in this booklet for more information.

State withholding is optional for out-of-state residents.

- ☐ Do not withhold State of California income tax.
- ☐ Withhold State of California income tax in the amount of $ _____ Dollars per month.
- ☐ Withhold State of California income tax based on the tax tables for:
  - ☐ A married individual with _____ Number tax withholding exemptions.
  - ☐ A single individual with _____ Number tax withholding exemptions.

  In addition to the amount withheld based on the tax tables, withhold $ _____ Dollars per month.
- ☐ Withhold State of California income tax in the amount of 10 percent of the federal income tax withholding amount.

Put your name and Social Security number at the top of every page

Your Name | Social Security Number

Section 9

Member Signature and Notary

This section must be completed or your application will be returned.

If your spouse's or domestic partner's signature is not available, See instructions in this booklet on completing the Justification for Absence of Signature form. Your signature and your spouse's or domestic partner's signature must be notarized by a notary public or witnessed by a CalPERS representative.

I certify, under the penalty of perjury, that the information submitted hereon is true and correct to the best of my knowledge. I understand to cancel this application or to change the elected option or beneficiary I must notify CalPERS before the mailing of my first full monthly retirement allowance check.

I understand that if I am married or in a registered domestic partnership, but do not name my spouse or partner as beneficiary, they may still be entitled to a community property share of the Option 1 lump sum return of contributions benefit **or** a share of the monthly option death benefit allowance. Their community property interest is 50% of the benefit based on the contributions or service credit earned for the period of CalPERS service during which we were married or in a registered partnership. My non-spouse or non-partner designated beneficiary will receive the portion of the lump sum Option 1 benefit or monthly option allowance that is not payable to my spouse or domestic partner. I understand that my spouse or domestic partner will have the right to disclaim entitlement to their community property interest in the death benefit at the time the benefit becomes payable, if they so desire.

More detailed information on this section is available in this booklet.

Are you legally married or do you have a legal domestic partner? ☐ Yes ☐ No

If yes, your spouse or domestic partner must sign this election.

If no, please indicate: ☐ Never Married/or in Partnership ☐ Divorced/Annulled ☐ Widowed Or Termination of Domestic Partnership

Your Signature | Date (mm/dd/yyyy)

Your Spouse's or Domestic Partner's Signature | Date (mm/dd/yyyy)

State of California, County of _____

On _____ (Date) before me, _____ (Name of Notary/Witness)

personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument. I certify under **Penalty of Perjury** under the laws of the State of California that the foregoing paragraph is true and correct.

Notary Seal

Witness my hand and official seal **or** authorized CalPERS representative signature.

Signature of Notary or CalPERS Representative | Position Title | Date (mm/dd/yyyy)

Print Name | CalPERS Office (if applicable)

Mail to: **CalPERS Benefit Services Division** • P.O. Box 942711, Sacramento, California 94229-2711

Employer Services Division
P.O. Box 942709
Sacramento, CA 94229-2709
Telecommunications Device for the Deaf - (916) 795-3240
888 CalPERS (or **888**-225-7377) FAX (916) 795-3005

Reply to Section 104:
S.S.A.#: _____

February 1, 2007

TO: _____ Unit: _____
(Employer Code and Name)

RE: _____
(Member/Employee Name)

The birthdate, _____, currently shown on our records differs from the birth date originally submitted by your agency.

It is necessary that we determine the source of this discrepancy. Please review your records and return the completed questionnaire below.

Corporate Registration Unit
Employer Services Division

EMPLOYER RESPONSE

The birth date given by this member is: _____

REASON FOR DISCREPANCY:

_____ Member has reported more than one birth date, **birth certif. enclosed**.
_____ Agency clerical or typographical error.
_____ Birth Certificate attached - Birth date does not agree with PERS record.

EMPLOYER CERTIFICATION

_____
(Signature of Certifying Officer)

_____ _____
(Agency Phone #) (Date)

PERS-MEM-12

Request for Service Credit Cost Information - Service Prior to Membership, CETA & Fellowship Service

888 CalPERS (or 888-225-7377) • TTY: For Speech & Hearing Impaired (916) 795-3240

Name of Member (Last Name, First Name, Middle Initial) | Social Security Numb

Section 1 — About You

If we have provided cost information to you in the past for this service credit, check the Yes box and indicate the date your request was submitted. If you have submitted a retirement application, check the Yes box and indicate your planned retirement date.

Have you requested this cost information before? ☐ No ☐ Yes _____ Requested Date (mm/dd/yyyy)

Have you submitted a retirement application? ☐ No ☐ Yes _____ Requested Date (mm/dd/yyyy)

Were you compensated for this employment? ☐ No ☐ Yes _____ Requested Date (mm/dd/yyyy)

Former Name (if applicable) | Current Employer

Mailing Address

City | State | ZIP Code | Daytime Phone

Section 2 — Prior Employment Information

List the name and address of the employer where the service was earned. If this was a certificated position, contact the State Teachers' Retirement System.

List the dates and hours of employment for which you are requesting credit. List each position separately and indicate if service was full time or part time. If the service was part time, show service as a fraction or list the hours (i.e., 20 hours per month or half time).

Employer

Address

City | State | ZIP Code

Was this service rendered under the Comprehensive Employment & Training Act from 1973 to 1982? ☐ No ☐ Yes

Was this service rendered under a fellowship program? ☐ No ☐ Yes _____ Name of Program

Was service rendered as a 10-month employee? ☐ No ☐ Yes

Employment From (mm/dd/yyyy) | To (mm/dd/yyyy) | Location

Position Title | Hours Worked Per Month OR Time Base/Fraction of Full Time

Employment From (mm/dd/yyyy) | To (mm/dd/yyyy) | Location

Position Title | Hours Worked Per Month OR Time Base/Fraction of Full Time

Employment From (mm/dd/yyyy) | To (mm/dd/yyyy) | Location

Position Title | Hours Worked Per Month OR Time Base/Fraction of Full Time

Section 3 — Member Certification

I hereby certify that the above information is true and correct.

Signature | Date (mm/dd/yyyy)

- If the service was performed for the State of California or a California State University, STOP. Sign this form on the line above and mail it to CalPERS.
- If the service was performed for the University of California, a CalPERS-covered public agency, or a school, forward this request form to the appropriate employer for completion of Page 2 before returning to CalPERS.

Name of Member (Last Name, First Name, Middle Initial) | Social Security Number — —

Section 4

Statement & Signature of Personnel or Payroll Officer

If the service was performed for the State of California or California State University, employer certification is not required.

Your signature certifies that the member-provided information is true, correct, and provides CalPERS with all the necessary information to apply any exclusions. If no hours worked or time base is indicated, **full-time service** will be assumed. If you do not agree with this assumption or with the information listed, continue to Section 5.

Position Type ☐ Seasonal ☐ Limited Term ☐ On-Call ☐ Intermittent ☐ Permanent

For Teachers Assistants Only:
Was this person employed pursuant to Section 44926 of the Education Code? ☐ No ☐ Yes

Do you feel this service is eligible for purchase? ☐ Yes ☐ No ______ Reason

Employer Signature | Title | Date (mm/dd/yyyy)

Printed Name | Phone | FAX

Section 5

Employer Certification

To be completed by employer only if additional information is necessary. Otherwise, simply certify in Section 4 above.

Complete Section 7 and return this request form to the member.

Position Title | Employment From (mm/dd/yyyy) | To (mm/dd/yyyy)

Time Base ☐ Full Time ☐ Part Time ☐ Hourly ☐ Fraction of Full Time

Average Number of Days or Hours Per Month ______

Average Percentage or Fraction of Time Worked Per Month ______

Section 6

Member Employment History

Complete Section 6 only if the employee was full time, worked more than 1,000 hours in a fiscal year (July 1 through June 30), or did not work a consistent time base and could not be listed above.

Employment From (mm/dd/yyyy) | Employment To (mm/dd/yyyy) | Position Title

Pay Rate (Hourly/Daily/Monthly) | Time Worked (Hours Per Day) | Time Worked (Earnings)

Employment From (mm/dd/yyyy) | Employment To (mm/dd/yyyy) | Position Title

Pay Rate (Hourly/Daily/Monthly) | Time Worked (Hours Per Day) | Time Worked (Earnings)

Employment From (mm/dd/yyyy) | Employment To (mm/dd/yyyy) | Position Title

Pay Rate (Hourly/Daily/Monthly) | Time Worked (Hours Per Day) | Time Worked (Earnings)

Employment From (mm/dd/yyyy) | Employment To (mm/dd/yyyy) | Position Title

Pay Rate (Hourly/Daily/Monthly) | Time Worked (Hours Per Day) | Time Worked (Earnings)

Section 7

Statement & Signature of Personnel or Payroll Officer

If the service was performed for the State of California or California State University, employer certification is not required.

I hereby certify that the above information is true and correct and provides CalPERS with all the necessary information to apply any exclusions.

Signature | Title | Date (mm/dd/yyyy)

Printed Name | Phone | FAX

Mail to: **CalPERS Member Services Division** • P.O. Box 4000, Sacramento, California 95812-4000

Request for Service Credit Cost Information - Leave of Absence

888 CalPERS (or 888-225-7377) • TTY: For Speech & Hearing Impaired (916) 795-3240

Name of Member (Last Name, First Name, Middle Initial) | Social Security Number

Section 1

About You

Have you requested this cost information before? ☐ No ☐ Yes ______ Requested Date (mm/dd/yyyy)

Have you submitted a retirement application? ☐ No ☐ Yes ______ Retirement Date (mm/dd/yyyy)

Former Name (if applicable) | Current Employer

Mailing Address

City | State | ZIP Code | Daytime Phone

Section 2

Employment Information

List the name and address of the employer that granted the leave.

Employer

Address

City | State | ZIP Code

Dates of Leave From (mm/dd/yyyy) | To (mm/dd/yyyy) | Type/Purpose of Leave: ☐ Maternity/Paternity ☐ Educational ☐ Service ☐ Sabbatical ☐ Temporary Disability

Dates of Leave From (mm/dd/yyyy) | To (mm/dd/yyyy) | Type/Purpose of Leave: ☐ Maternity/Paternity ☐ Educational ☐ Service ☐ Sabbatical ☐ Temporary Disability

Dates of Leave From (mm/dd/yyyy) | To (mm/dd/yyyy) | Type/Purpose of Leave: ☐ Maternity/Paternity ☐ Educational ☐ Service ☐ Sabbatical ☐ Temporary Disability

Dates of Leave From (mm/dd/yyyy) | To (mm/dd/yyyy) | Type/Purpose of Leave: ☐ Maternity/Paternity ☐ Educational ☐ Service ☐ Sabbatical ☐ Temporary Disability

Section 3

Certification

Give the form to the employer that granted the leave to complete Section 4 (and to route to the compensation carrier to complete Sections 5 and 6).

Member Signature | Date (mm/dd/yyyy)

Section 4

Leave of Absence Certification (to be completed by employer)

Employer: Return the completed form to the member or forward it to the member's Workers' Compensation carrier, as appropriate.

Dates of Leave From (mm/dd/yyyy) | To (mm/dd/yyyy) | Type/Purpose of Leave: ☐ Maternity/Paternity ☐ Educational ☐ Service ☐ Sabbatical ☐ Temporary Disability

I hereby certify that the above information is true and correct.

Employer Signature | Title | Date (mm/dd/yyyy)

Printed Name | Phone | FAX

Name of Member (Last Name, First Name, Middle Initial) | Social Security Number

Section 5 — Temporary Disability Leave of Absence Certification

To be completed by the Workers' Compensation carrier that provides temporary disability benefits.

* If there was more than one temporary disability leave period, provide claim numbers and dates for each.

Workers' Compensation Carrier Information

Name of Employer's Disability Carrier

Carrier's Address | Carrier's Phone Number

Employee's Claim Number* | Beginning Date of Temporary Disability Payments (mm/dd/yyyy) | Ending Date of Payments (mm/dd/yyyy)

Effective Date of Permanent Disability Rating*

Was there a settlement by Compromise and Release? ☐ No ☐ Yes. Provide copy.

Section 6 — Signature of Authorized Workers' Compensation Carrier Representative

Please return the completed form to the member.

I hereby certify that the above information is true and correct.

Carrier Signature | Date (mm/dd/yyyy)

Printed Name | Title

Mail to: **CalPERS Member Services Division** • P.O. Box 4000, Sacramento, California 95812-4000

Request for Service Credit Cost Information - Layoff, Prior Service & Optional Member Service

888 CalPERS (or 888-225-7377) • TTY: For Speech & Hearing Impaired (916) 795-3240

Name of Member (Last Name, First Name, Middle Initial) | Social Security Number — —

Section 1 About You

Have you requested this cost information before? ☐ No ☐ Yes _____ Requested Date (mm/dd/yyyy)

Have you submitted a retirement application? ☐ No ☐ Yes _____ Retirement Date (mm/dd/yyyy)

Former Name (if applicable) | Current Employer

Mailing Address

City | State | ZIP Code | Daytime Phone

Section 2 Employment Information

List information about your employer at the time of your layoff, prior service, or optional member service.

Employment From (mm/dd/yyyy) | Employment To (mm/dd/yyyy) | Employer

Employment From (mm/dd/yyyy) | Employment To (mm/dd/yyyy) | Employer

Employment From (mm/dd/yyyy) | Employment To (mm/dd/yyyy) | Employer

Employment From (mm/dd/yyyy) | Employment To (mm/dd/yyyy) | Employer

Section 3 Certification

Give this form to your employer at the time of your layoff, prior service, or optional member service for completion of Sections 4, 5, and 6 before returning to CalPERS.

I hereby certify that the above information is true and correct.

Member Signature | Date (mm/dd/yyyy)

Name of Member (Last Name, First Name, Middle Initial) | Social Security Number

Section 4 — Employer Certification (to be completed by former employer)

For Layoff, list the dates the member was laid off work.

Member Layoff History

Date From (mm/dd/yyyy) | Date To (mm/dd/yyyy)

For Prior Service, complete the detailed history for the employment dates and time worked. Remember, to be eligible the employment period must be prior to your CalPERS contract date.

Member Prior Service History

Did your agency have a local retirement system (prior to CalPERS contract)? ☐ No ☐ Yes

Was this member a participant of the local retirement system? ☐ No ☐ Yes

Did the member withdraw these funds? ☐ No ☐ Yes | Service Time | Amount Withdrawn | Withdrawal Date

Plan Type: ☐ Defined Benefit ☐ Defined Contribution

Optional Member Service

For Optional Member Service, complete the questions on the optional period, as well as the detailed history.

Was this position filled by an election or appointment to a fixed term of office? ☐ Election ☐ Appointment

Position Title

Was compensation paid considered a salary? (Expense reimbursement is not a salary.) ☐ No ☐ Yes

Section 5 — Member Employment History

Be sure to include employment dates, pay rate, time worked, and earnings for the optional period.

Employment From (mm/dd/yyyy)	Employment To (mm/dd/yyyy)	Time Worked (hour/days)	Earnings

Section 6 — Statement & Signature of Personnel or Payroll Officer

If the service was performed for the State of California or California State University, employer certification is not required.

I hereby certify that the above information is true and correct.

Employer Signature | Title | Date (mm/dd/yyyy)

Printed Name | Phone | FAX

Employer: Please return the completed form to the member.

Mail to: **CalPERS Member Services Division** • P.O. Box 4000, Sacramento, California 95812-4000

Physical Requirements of Position/Occupational Title

888 CalPERS (or 888-225-7377) • TTY for Speech and Hearing Impaired: (916) 795-3240 • Fax: (916) 795-1280

Section 1 Member Information

This form must be completed by the member and their employer to supplement, if any, the physical requirements listed on the member's duty statement/job description.

Name of Member (First Name, Middle Initial, Last Name) _____ Social Security Number _____ – _____ – _____

Position/Occupational Title _____ Name of Employer _____

Worksite Street Address _____

City _____ State _____ ZIP _____

Section 2 Physical Requirements Information

Indicate with a check mark (✓) the frequency required for each activity listed at the right.

Activity	Never	Occasionally Up to 3 hours	Frequently 3–6 hours	Constantly Over 6 hours	Distance/ Height
Sitting					
Standing					
Running					
Walking					
Crawling					
Kneeling					
Climbing					
Squatting					
Bending (neck)					
Bending (waist)					
Twisting (neck)					
Twisting (waist)					
Reaching (above shoulder)					
Reaching (below shoulder)					
Pushing & Pulling					
Fine Manipulation					
Power Grasping					
Simple Grasping					
Repetitive use of hand(s)					
Keyboard Use					
Mouse Use					
Lifting/Carrying					
0 – 10 lbs.					
11 – 25 lbs.					
26 – 50 lbs.					
51 – 75 lbs.					
76 – 100 lbs.					
100 + lbs.					

Continued on page 2.

Put your name and Social Security number at the top of every page.

Your Name | Social Security Number

Section 2 (continued)

Physical Requirements, continued

Indicate with a check mark (✓) the frequency required for each activity listed at the right.

Activity	Never	Occasionally Up to 3 hours	Frequently 3–6 hours	Constantly Over 6 hours	Distance/ Height
Walking on uneven ground					
Driving					
Working with heavy equipment					
Exposure to excessive noise					
Exposure to extreme temperature, humidity, wetness					
Exposure to dust, gas, fumes, or chemicals					
Working at heights					
Operation of foot controls or repetitive movement					
Use of special visual or auditory protective equipment					
Working with bio-hazards (e.g., blood-borne pathogens, sewage, hospital waste, etc.)					

Comments or additional requirements not listed above:

Section 3

Signature of Employer and Member

The employer must give the member a copy of this form once it has been completed and signed by both parties. The employer then sends the original to CalPERS. The member must attach their current duty statement/job description and copy of the Physical Requirements of Position/Occupational Title form to the Physician's Report on Disability prior to sending to their physician.

Signature of Employer Representative | Date (mm/dd/yyyy)

Title | ( ) Phone Number

Signature of Member | ( ) Phone Number | Date (mm/dd/yyyy)

Mail to: **CalPERS Benefit Services Division** • P.O. Box 2796, Sacramento, California 95812-2796

Employer Information for Disability Retirement

888 CalPERS (or 888-225-7377) • TTY for Speech and Hearing Impaired: (916) 795-3240 • Fax: (916) 795-1280

Section 1 — Member Information

To Member: Complete this form, sign, date and forward to your employer.

To Employer: Use this form as a cover sheet for the employee's job description and other documents you submit to CalPERS.

Name of Member (First Name, Middle Initial, Last Name) | Social Security Number

Position/Occupational Title | Name of Employer/Agency

I have submitted an application for disability retirement with the California Public Employees' Retirement System (CalPERS). I am submitting this letter to you (my employer) on behalf of CalPERS. CalPERS is seeking information to substantiate my disability.

As soon as possible, please send CalPERS the duty statement/job description for the position I held. Please include a copy of all accident reports, medical reports, and personnel actions filed within the past five years. These documents must be identified with my name and Social Security number. If you have additional comments, please submit them.

CalPERS requires the physical requirements of my position/occupational title. I will be contacting you so we can complete the Physical Requirements of Position/Occupational Title form for my position. At that time, a copy of my duty statement/job description that you send to CalPERS must be provided to me. Both the duty statement/job description and the Physical Requirements of Position/Occupational Title form will be presented to my physician to assist in the evaluation of my disability retirement.

When the CalPERS determination of disability is completed, they will inform you. When you are notified of their determination, you will have the right to appeal the approval/denial of the application for disability retirement for the medical condition stated, in accordance with Section 555.3, Title II, California Code of Regulations by filing a written request with CalPERS within 30 days of the mailing of the determination letter. An appeal, if filed, should set forth the factual basis and legal authorities for such appeal.

Under the law, if a person (other than my employer) caused an injury that results in certain CalPERS benefits being paid, CalPERS has the right to recover from the responsible party up to one-half of the total retirement benefit costs payable. This right is known as a "right of subrogation" (Government Code Section 20250, et seq.).

Please advise CalPERS if you are aware of any claim (other than a workers' compensation claim) against any person or entity for the same injuries that also entitle me to a disability retirement from CalPERS.

Section 2 — Authorization to Release Information

Mail signed authorization to your empoyer, not CalPERS.

The purpose of this authorization is to assist CalPERS in determining my right to retirement or reinstatement under the Retirement Law, pursuant to Government Code Section 20128, and for no other purpose. This authorization will be valid for four years from the date shown below. A photocopy of this authorization shall be as valid as the original.

Signature of Member | Date (mm/dd/yyyy)

Mail to: **CalPERS Benefit Services Division** • P.O. Box 2796, Sacramento, California 95812-2796

STATE OF CALIFORNIA - CALIFORNIA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SEPARATION/DISPOSITION OF CALPERS CONTRIBUTIONS

STD. 687 (REV. 11/2006)

THE FOLLOWING CONTAINS INFORMATION ON THE RIGHTS OF MEMBERS IF THEY ARE SEPARATING FROM STATE EMPLOYMENT, WHICH INCLUDES ACCEPTING A POSITION AT A PUBLIC AGENCY COVERED BY ANOTHER CALIFORNIA PUBLIC RETIREMENT SYSTEM, CREATING RECIPROCAL RIGHTS

NOTE: If you are moving from one CalPERS covered employer to another, you may not withdraw your CalPERS contributions

A. NOTICE TO FIRST TIER MEMBERS ELECTING A REFUND OF RETIREMENT CONTRIBUTIONS

The refund you receive from CalPERS is subject to 20% Federal income tax withholding. Withholding applies only to the portion of your refund that is subject to Federal income tax (i.e., interest your contributions have earned and any tax deferred contributions, if applicable). Whether you elect to receive your refund or roll it over, you have the option of having 2% of the taxable portion withheld for California state income tax. **For additional information on income tax, rollovers, and excise tax, refer to the BAS-500, "IMPORTANT CALPERS REFUND TAX INFORMATION", attached.**

B. NOTICE TO SECOND TIER MEMBERS WHO ARE TERMINATING EMPLOYMENT

If you are a vested Second Tier member, and you terminate your employ- ment, your service will be placed in a deferred retirement status without action on your part. When you reach age 55, you will be eligible to receive a retirement allowance from CalPERS. *(You are vested if you have at least 10 years of service credit.)*

C. ALL MEMBERS WHO ACCEPT EMPLOYMENT COVERED BY A RETIREMENT SYSTEM HAVING A RECIPROCAL AGREEMENT WITH CALPERS

At present the following are CalPERS reciprocal systems:

- 1937 Act County System (inclusive of Districts affiliated with each County Retirement System):

Alameda	Mendocino	San Mateo
Contra Costa	Merced	Santa Barbara
Fresno	Orange	Sonoma
Imperial	Sacramento	Stanislaus
Kern	San Bernardino	Tulare
Los Angeles	San Diego	Ventura
Marin	San Joaquin	

- The University of California

- Other California Public Agencies:
Cities of Concord, Costa Mesa (safety only), Fresno, Oakland (non-safety), Pasadena, Sacramento, San Clemente (non-safety), San Diego, and San Jose; East Bay Municipal Utility District, East Bay Regional Park District; Contra Costa Water District; County of San Luis Obispo, and the City and County of San Francisco; Long Beach Schools Business Management Authority; Los Angeles City Retirement System; Los Angeles County Metropolitan Transportation Authority, California Administrative Services Authority.

1. As a member of CalPERS accepting employment covered by one of the reciprocal retirement systems, you will have certain rights if:
   a. You enter employment in which you become a member of a reciprocal system within 6 months after separating from CalPERS-covered employment, and
   b. You elect to leave your contributions on deposit with CalPERS and inform CalPERS of the name of the public agency in which you will be or are employed.
2. The rights of such membership if continued are:
   a. The final compensation used to determine your benefits under CalPERS will be the highest earned under the two systems provided you retire concurrently under both systems;
   b. Your service under all reciprocal systems will be considered to determine eligibility for benefits under the several systems;
   c. The basic death benefit or disability retirement;
   d. A rate of contribution to the public agency retirement system based on your age of entry into membership in CalPERS or another reciprocal retirement system.
3. Contributions you elect to leave on deposit in CalPERS **may not be withdrawn** while you remain in employment covered by one of the reciprocal systems.
4. If you wish to advise CalPERS directly of your election to establish reciprocity, please send written correspondence to the address listed under Section D.

   NOTE: Be sure to notify CalPERS of any future address change to ensure delivery of your Annual Member Statement.

D. ALL MEMBERS WHO ACCEPT EMPLOYMENT COVERED BY THE STATE TEACHERS 'RETIREMENT SYSTEM, LEGISLATORS' RETIREMENT SYSTEM, OR THE JUDGES' RETIREMENT SYSTEM I/II

1. As a member of CalPERS accepting employment covered by the State Teachers' Retirement System, Legislators' Retirement System, or Judges' Retirement System I/II, you will have certain rights if you elect to leave your contributions on deposit with CalPERS and inform CalPERS of the name of the other retirement system.
2. If you elect to continue your membership, the final compensation used to determine your benefits under CalPERS will be the highest earned under the two systems provided you retire concurrently under both systems.
3. Contributions you elect to leave on deposit in CalPERS **may not be withdrawn** while you remain in employment covered by one of these retirement systems.
4. If you wish to advise CalPERS directly of your employment covered by one of these retirement systems, please send written correspondence to the following address.

   CalPERS
   Member Services Division, Unit 841
   P. O. Box 942704
   Sacramento, CA 94229-2704
   (888) CalPERS 225-7377
   Telecommunications Device for the Deaf
   (916) 795-3240; FAX (916) 795-1224

NOTE: Be sure to notify CalPERS of any future address change to ensure delivery of your Annual Member Statement.

NOTE: A rollover to CalPERS from your Alternate Retirement Plan that is administrated by the Department of Personnel Administration will not be allowed if your CalPERS account has been refunded.

PRIVACY NOTIFICATION

The information you are asked to provide on this form is requested by the Office of the State Controller, Personnel/Payroll Services Division. This notice is required by Section 1798.17 of the Information Practices Act of 1977 (California Civil Code Sections 1798 through 1798.76) and the Federal Privacy Act (5 USC 552a, subd. (e)(3)) to be provided whenever an agency requests personal information from an individual.

The information on this form is to be used by the State Controller's Office and the Public Employees' Retirement System (CalPERS) for the purposes of identification and processing retirement contributions. Where authorized by law, address information may be transferred to the following governmental agencies: Internal Revenue Service and Franchise Tax Board. Certain items of information provided on this form may be transferred to the following governmental agencies where authorized by law: Employment Development Department, Department of Social Services, Social Security Administration, Federal Internal Revenue Service, California State Franchise Tax Board, other state income tax bureaus, and other governmental entities when required by state or federal law.

It is mandatory that you furnish the information requested on this form. Failure to furnish the requested information may result in an inaccurate determination of credit for State service, payroll calculations, and retirement and/or health benefits.

Legal references authorizing maintenance of this information include the Internal Revenue Code, Sections 6011, 6051 and 6109 (26 USCA 6011, 6051, 6109), and the regulations thereto.

Employees have the right to review their own personal information maintained by the State Controller's Office, unless access is exempted by law. The following office is responsible for the system of records and shall, upon request, inform you of the location of your records and the categories of persons using the information therein: Personnel/Payroll Services Division, State Controller's Office, P. O. Box 942850, Sacramento, CA 94250-5878.

STATE OF CALIFORNIA - CALIFORNIA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SEPARATION/DISPOSITION OF CALPERS CONTRIBUTIONS

STD. 687 (REV. 11/2006)

IMPORTANT CALPERS REFUND TAX INFORMATION

The following consists of summarized tax information and is provided in accordance with Section 402(f) of the Internal Revenue Code. ***AS CALPERS CANNOT PROVIDE SPECIFIC INFORMATION OR TAX ADVICE, PLEASE SEE YOUR TAX CONSULTANT, THE INTERNAL REVENUE SERVICE OR THE STATE FRANCHISE TAX BOARD. FOR ADDITIONAL INFORMATION CONCERNING ROLLOVERS, CONSULT THE APPROPRIATE FINANCIAL INSTITUTION OF YOUR CHOICE.***

ROLLOVERS - An "eligible rollover distribution" consists of the taxable portion of a refund of your contributions, including interest, due to a separation from all CalPERS-covered employment. You may avoid current taxation on any portion of the taxable amount of an eligible rollover distribution by rolling over that portion into an individual retirement arrangement (IRA) or another qualified employer retirement plan that accepts rollover contributions. A tax-free rollover of the taxable amount of an eligible rollover distribution may be accomplished in one of the following ways:

1) **Direct Rollover** -You may direct CalPERS to transfer all or anyportion of the taxable amount of the distribution to a specified IRA or qualified defined contribution plan that accepts rollovers. It cannot be made to another defined benefit plan such as CalPERS. However, the portion to be directly rolled over must be at least $500. Taxes will be reportable when you take the money out of an IRA or other qualified plan.

2) **Regular Rollover** -You may take an in-hand distribution and, **not later than 60 days after you receive the distribution,** transfer all or a portion of the taxable portion of the distribution to an IRA or qualified plan that accepts rollovers. Taxes will be reportable when you take the money out of an IRA or other qualified plan.

Even if you plan to roll over the taxable portion of the eligible distribution, *unless you elect a Direct Rollover, you will only receive 80% of your distribution.* Federal tax rules require CalPERS to automatically deduct 20% federal tax withholding from the taxable portion of your refund, if it is over $200.

If you wish to make the Regular Rollover for the full 100%, you will have to make up the 20% difference out-of-pocket. You will also be taxed on the 20% that was withheld. When filing your individual tax return you then can get a refund of the amount withheld to the extent you have no further tax liability.

Early distributions from a qualified retirement plan are subject to an early withdrawal penalty tax of 10% federal and 2 1/2% State tax on the taxable portion of the distribution PLUS any income tax due on the distribution if it is received prior to age 59 1/2, unless an exception applies.

Please be aware not all distributions are eligible to be rolled over. Any distribution that is part of a series of substantially equal periodic payments made at least annually under a life annuity, over life expectancy or over a specified period of 10 or more years is ineligible to be rolled over. Also ineligible for rollover treatment is the amount of a distribution that is necessary to satisfy the minimum distribution requirements that apply after you separate from employment or you turn age 70 1/2, whichever occurs later.

EXCEPTION TO THE ADDITIONAL TAX - There are some instances where an individual will be exempt from the early withdrawal penalty tax even if he/she takes an early distribution from a qualified retirement plan. These are as follows:

1) receipt of a CalPERS service or disability retirement benefit, paid as a monthly allowance over you/your beneficiary's life; or

2) a lump sum distribution, if made to a beneficiary because of your death; or

3) a lump sum distribution, if made to you because of your separation from service after attaining age 55 or after becoming disabled.

4) Effective 1/1/07 – The 10%. Federal penalty tax will be waived when you receive a lump sum distribution, if made to you because of your separation from service after attaining age 50 and you were a safety member who provided police protection, firefighting service or emergency medical services

FIVE AND TEN-YEAR AVERAGING / CAPITAL GAIN - If you receive a lump sum distribution after you are age 59 1/2, you may be able to make a one-time election to figure the tax on the payment by using ***"5-year averaging"***. To qualify for 5-year tax averaging, you must be at least age 59 1/2 and have participated in CalPERS (the plan making the distribution) for no less than 5 years before the year the distribution is made.

If you receive a lump sum distribution and you were born before January 1, 1936, you can make a one-time election to figure the tax on the payment by using *"10-year averaging"* (using 1986 tax rates). Only one election is available to an individual, and if made, eliminates the ability to elect 5-year averaging and capital gain treatment after attaining age 59 1/2. However, any 10-year averaging election made prior to January 1, 1987, and before attaining age 59 1/2, does not count toward your one election.

If you were born prior to January 1, 1936 and you receive a lump sum distribution, any pre-1974 CalPERS contributions you paid (if applicable) may be taxed as long-term *"capital gain"* at a rate of 20%.

CALIFORNIA STATE TAX WITHHOLDING - Whether you elect to receive a refund OR directly roll over your contributions, you may choose to have state tax withheld or not withheld. State tax, if withheld, is 2% of the taxable portion of the refund. An individual also has the right to revoke or change their choice prior to the mailing of their contributions.

For California residents who do not make a choice, 2% will *automatically* be withheld for State tax even if you elect a rollover.

For **individuals who reside outside of California**, no state tax will be withheld unless specifically requested. Please be aware that you may still owe California state taxes.

Publications are available from the Internal Revenue Service which provide specific information on special tax treatment on lump sum distributions. If you have state tax liability questions, contact the State Franchise Tax Board.

(BAS-500)

STATE OF CALIFORNIA - CALIFORNIA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SEPARATION/DISPOSITION OF CALPERS CONTRIBUTIONS

STD. 687 (REV. 11/2006)

Use ballpoint pen and return completed form to your Personnel Office.

A PERSONNEL OFFICE USE — 01 AGENCY | 02 UNIT | 03 ADD'L IDENTIFICATION

B 01 SOCIAL SECURITY NUMBER | 02 EMPLOYEE LAST NAME | 03 FIRST NAME AND MIDDLE INITIAL

SEPARATION DATE AND TYPE OF SEPARATION (Check One)

C 01 SEPARATION DATE — MONTH DAY YEAR

02 ☐ **RESIGNATION** — This resignation is executed by me freely and voluntarily and of my own free will and is not given by reason of any threat, force, duress, or any undue influence by any person (Sign in Section G).

REASON FOR RESIGNATION

03 ☐ **SEPARATION WITHOUT FAULT BY DEPARTMENT OR CAMPUS**

04 ☐ **OTHER**

DISPOSITION OF CALPERS CONTRIBUTIONS (Check One Box Only) IF YOU ARE RETIRING, DO NOT COMPLETE THIS SECTION

D

TO TERMINATE MEMBERSHIP--To be eligible for a refund you must have service under the first tier and be permanently separating from ALL CALPERS-covered employment. Before checking either box, read the information contained in Section A on the reverse side of the employee copy.

NOTE: A rollover to CalPERS from your Alternate Retirement Plan that is administrated by the Department of Personnel Administration will not be allowed if your CalPERS account has been refunded.

01 ☐ **I ELECT TO TERMINATE MY MEMBERSHIP IN CALPERS AND DIRECTLY RECEIVE A REFUND OF MY TOTAL CONTRIBUTIONS. I UNDERSTAND THAT 20% OF THE TAXABLE AMOUNT WILL BE WITHHELD FOR FEDERAL INCOME TAXES AS DESCRIBED IN THE ATTACHED BAS-500 FORM.**

02 ☐ **I ELECT TO TERMINATE MY MEMBERSHIP IN CALPERS AND DIRECTLY ROLLOVER THE TAXABLE PORTION OF MY TOTAL CONTRIBUTIONS TO THE FINANCIAL INSTITUTION OR PLAN NAMED ON THE CALPERS DIRECT ROLLOVER ELECTION, ATTACHED.**

***IMPORTANT:* NO REFUND OR ROLLOVER OF A REFUND WILL BE PROCESSED IF YOUR INITIALS DO NOT APPEAR AFTER THE WAIVER OF RIGHTS STATEMENT:**

I am aware of my service and disability rights under CalPERS. I have read the description of rights, and the benefit calculation formula and table set forth in the CalPERS member booklet for my classification. Despite my knowledge of these facts, I hereby WAIVE all rights and understand that by requesting a refund, I am forfeiting all future retirement benefits.

✍ (Member's Initials)

TO CONTINUE MEMBERSHIP – Contributions, if any, will continue to earn interest, and you will not accrue further service unless you return to CalPERS-covered employment. If you have 5 years of service credit and elect to leave your contributions on deposit, you can apply for service retirement at age 50 and receive a monthly allowance. For a retirement estimate, use the "calculator" on CalPERS Website at www.calpers.ca.gov. Before checking either box, read the information contained in Sections B through D on the reverse side of the employee copy.

03 ☐ **I ELECT TO CONTINUE MEMBERSHIP IN CALPERS AND LEAVE MY CONTRIBUTIONS AND/OR SERVICE CREDIT ON DEPOSIT.**

04 ☐ **I ELECT TO CONTINUE MEMBERSHIP IN CALPERS AND ESTABLISH RECIPROCITY (AS EXPLAINED IN SECTIONS D AND E ON THE REVERSE SIDE OF THE EMPLOYEE COPY) BY ACCEPTING EMPLOYMENT WITH THE FOLLOWING PUBLIC AGENCY, WHICH PROVIDES MEMBERSHIP IN ANOTHER CALIFORNIA PUBLIC RETIREMENT SYSTEM.**

(Enter name of Public Agency / Retirement System / University of California)

CALIFORNIA STATE TAX WITHHOLDING (Before checking either box, read the information contained in the form BAS-500)

E I ELECT TO HAVE 2% OF THE TAXABLE PORTION WITHHELD FOR STATE INCOME TAX (APPLICABLE TO **OUT-OF-STATE** RESIDENTS ALSO)

01 ☐ YES OR 02 ☐ NO

MAILING ADDRESS-Your Wage and Tax Statement (Form W-2) and any final warrants and/or retirement refund will be mailed to the address entered below.

F 01 EMPLOYEE ADDRESS (Street, Rural Route or P. O. Box) | 02 CITY | STATE | 03 ZIP CODE

EMPLOYEE /SPOUSAL/REGISTERED DOMESTIC PARTNER SIGNATURE-Spouse's/Registered Domestic Partner's signature is required for refund election. IMPORTANT-If not signed, the Justification for Nonsignature form must be completed.

G

EMPLOYEE: I certify that the above information is true and correct.

EMPLOYEE'S SIGNATURE ✍ | DATE SIGNED

SPOUSE/REGISTERED DOMESTIC PARTNER: I certify that I am aware of my spouse's/partner's request for a refund of contributions.

SPOUSE'S/DOMESTIC PARTNER'S SIGNATURE ✍ | DATE SIGNED

PERSONNEL OFFICE USE

H

01 ☐ **EMPLOYEE UNAVAILABLE** for completion of Section D. The employee has been advised that he/she must request the disposition of his/her retirement contributions in writing directly from CalPERS.

02 LAST DATE OF CONTRIBUTIONS — MO DAY YR

Enter the last date CalPERS contributions were or will be deducted from employee's pay. See instructions in PAM or CSU PIMS Manual.

REASON FOR EMPLOYEE'S UNAVAILABILITY

REVIEWER'S SIGNATURE ✍ | DATE SIGNED | PHONE

DISTRIBUTION: WHITE — Personnel/Payroll Services Division YELLOW — Personnel PINK — Employee

STATE OF CALIFORNIA - CALIFORNIA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SEPARATION/DISPOSITION OF CALPERS CONTRIBUTIONS

STD. 687 (REV. 11/2006)

JUSTIFICATION FOR NONSIGNATURE OF SPOUSE OR REGISTERED DOMESTIC PARTNER

Pursuant to Government Code Section 21261, the member's current spouse or registered domestic partner must be made aware of the selection of benefits or change of beneficiary made by a member. The spouse or registered domestic partner of a CalPERS member must acknowledge the submission of a request for refund of contributions.

If a spouse's or registered domestic partner's signature does not appear on the election to terminate CalPERS membership in Section G, the following information **MUST** be completed by the member.

SOCIAL SECURITY NUMBER	MEMBER'S NAME

APPLICATION SUBMITTED (Form Name and Number)

SEPARATION/DISPOSITION OF CALPERS CONTRIBUTIONS, STD. 687

☐ I am not legally married or do not have a registered domestic partner.

☐ I am married, but my spouse or registered domestic partner did not sign the form because:

- ☐ I do not know and have taken all reasonable steps to determine the whereabouts of my spouse or registered domestic partner; OR,
- ☐ My spouse or registered domestic partner has been advised of the refund application and has refused to sign the written acknowledgement; OR,
- ☐ My spouse or registered domestic partner is incapable of executing the acknowledgment because of an incapacitating mental or physical condition; OR,
- ☐ My spouse or registered domestic partner has no identifiable community property interest in the benefit; OR,
- ☐ My spouse or registered domestic partner and I have executed a spousal or domestic partner settlement agreement which makes the community property law inapplicable.

I CERTIFY UNDER PENALTY OF PERJURY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT.

MEMBER'S SIGNATURE	DATE SIGNED

STATE OF CALIFORNIA - CALIFORNIA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SEPARATION/DISPOSITION OF CALPERS CONTRIBUTIONS

STD. 687 (REV. 11/2006)

CalPERS DIRECT ROLLOVER ELECTION FORM

IMPORTANT: **The Rollover Election form must be completed and returned to CalPERS. YOUR ROLLOVER ELECTION CANNOT BE PROCESSED UNTIL THIS FORM IS RECEIVED BY CalPERS. Mail to: CalPERS, Section 445, P. O. Box 942711, Sacramento, CA 94229-2711.**

DO NOT SUBMIT A TRANSFER FORM FROM YOUR FINANCIAL INSTITUTION IN LIEU OF THE FOLLOWING INFORMATION.

Please either type or print clearly.

MEMBER NAME			SOCIAL SECURITY NUMBER
STREET ADDRESS*	CITY	STATE	ZIP CODE
DAYTIME TELEPHONE NUMBER ( )			

DIRECT ROLLOVER ELECTION

ROLL OVER THE TAXABLE PORTION OF MY RETIREMENT CONTRIBUTIONS DIRECTLY TO (Type of Account)

☐ IRA ☐ OTHER ELIGIBLE RETIREMENT PLAN

INSTITUTION OR PLAN NAME	ACCOUNT NUMBER

***The rollover warrant will be made payable to your financial institution or plan name and mailed to YOUR address.**

I certify that the institution / plan named above is eligible under the provisions of the Internal Revenue Code to accept a rollover by direct transfer and agrees to receive my CalPERS funds and deposit them as indicated.

MEMBER'S SIGNATURE	DATE SIGNED

Benefit Services Division
P.O. Box 942711
Sacramento, CA 94229-2711
888 CalPERS (or **888**-225-7377)
TDD - (916) 795-3240; FAX (916) 795-3988

Reply To: Section 445

Date

Name
Street
City, State Zip

Dear Member:

If you are in the process or have already separated from all CalPERS-covered employment, you will need to consider whether you want to keep your retirement contributions on deposit with CalPERS or receive a refund. **Please note that distributions made in the calendar year you attain age 70 ½ or later have special tax rules. If you are, or will be, 70 ½ this year please contact CalPERS to request a "Required Minimum Distribution" packet**.

Before making this important decision, please read all of the enclosed information. It contains information you will need to make an informed decision. If you do not understand your options as they are presented to you, please call our office at the toll free number above for clarification. Please carefully consider that a refund of your CalPERS retirement contributions is an irrevocable election to terminate your CalPERS membership and forfeit your right to future retirement, disability or death benefits, unless you are a vested member under State Second Tier.

If you are moving from one CalPERS-covered employer to another, you may not withdraw your retirement contributions. You must be permanently separated from all CalPERS-covered employment before you may terminate your CalPERS membership and receive a return of retirement contributions. In addition, CalPERS has agreements with many publicly funded retirement systems which permit movement between public employers within a specific time period without loss of retirement rights. If you are moving to a position covered under CalSTRS, Legislators' Retirement System, University of California Retirement Plan, Judges' I/II Retirement System or any of the agencies listed below, you may not be able to withdraw your retirement contributions. For additional information about your rights and responsibilities, you can download the publication "When You Change Retirement Systems" from our Web site or call us at the toll free number above.

Counties of:

Alameda	Contra Costa	Fresno	Imperial	Kern	Los Angeles
Marin	Mendocino	Merced	Orange	Sacramento	San Bernardino
San Diego	San Joaquin	Santa Barbara	San Mateo	Stanislaus	Sonoma
Tulare	Ventura				

Cities of:

Costa Mesa (safety only)	Fresno	Pasadena	San Diego	San Jose

And:

City and County of San Francisco	Contra Costa Water District
CA Admin Services Authority	East Bay Municipal Utility District
East Bay Regional Park District	Long Beach Schools Business Mgt System
Los Angeles City Retirement System	Los Angeles Co Metro Transportation Authority
Retirement Plan (UCRP) University of California	San Luis Obispo County

Please determine which bullet applies to you and read the applicable important information that should be considered before you decide to withdraw your contributions and terminate your membership in CalPERS.

- **If you have less than 5 years of service credit:** You are not a vested CalPERS member. If you decide to leave your contributions on deposit with CalPERS, you will continue to earn interest at the current rate of 6% APR and your membership will continue. No additional service credit will be earned unless you again become employed by a CalPERS-covered employer or acquire reciprocal rights with another California public retirement system. **Only if you become vested will you have the right to future retirement benefits. Exception:** If you have a job-related disability and are a safety member, you may qualify for Industrial Disability Retirement even if you have less than 5 years of service credit. Contact your employer or CalPERS for more information.

- **If you have at least 5 years of service credit and are younger than age 50:** You are a vested CalPERS member. You may leave your contributions on deposit with CalPERS, earning interest at the current rate of 6% APR. Then, once you attain age 50, the minimum age to qualify for service retirement, you can apply for retirement and receive a monthly allowance based on the service credit earned before you separated from employment. You should use the retirement estimate calculator on our Web site at www.calpers.ca.gov to find out what your allowance would be at age 50. If you are disabled, regardless of age, you may be eligible for disability retirement. Contact your employer or CalPERS for the disability retirement election/application package.

- **If you have at least 5 years of service credit and are age 50 or older:** You are a vested CalPERS member who qualifies for service retirement. You should use the retirement estimate calculator on our Web site at www.calpers.ca.gov to get an estimate of your retirement allowance before deciding if you want to withdraw your contributions, thus forfeiting your right to a monthly allowance. You may obtain a service retirement election/application package from your employer or CalPERS.

If you wish to leave your funds on deposit, you do not need to respond to this letter. You will continue to receive an Annual Member Statement every fall. If you move, please call CalPERS to update your address on our records.

If, after considering all information, you wish to withdraw your funds you may do so providing you:

1) **Have permanently separated from employment.**
2) **Are not moving to another CalPERS-covered employer.**
3) **Are not accepting a job covered by another California public retirement system.**

Your refund will be comprised of the retirement contributions in your account with interest at 6% through the date your payment is scheduled to the State Controller's Office. Once CalPERS receives the properly completed refund election form AND your employer has updated our system to show that you have separated from employment, it will take about 3 to 4 weeks for your payment to be issued.

Please be aware that the employer contributions are NOT refundable. The amount contributed by your employer goes into a separate fund that is used only to pay the pension portion of retirement or death benefits. If we can be of further assistance, please contact us.

Refunds Unit
Benefit Services Division

PERS02M0324 (05-2008)

Benefit Services Division
P.O. Box 942711
Sacramento, CA 94229-2711
888 CalPERS (or **888**-225-7377)
TDD - (916) 795-3240; FAX (916) 795-3988

Reply To: Section 445

REFUND TAX INFORMATION
RETAIN FOR FUTURE REFERENCE

The following consists of summarized tax information and is provided in accordance with Section 402(f) of the Internal Revenue Code. **CalPERS cannot provide specific information or tax advice. Please see your tax consultant, the Internal Revenue Service or the State Franchise Tax Board. For additional information concerning rollovers, consult the appropriate financial institution of your choice.**

Distributions made in the calendar year you attain age 70 ½ or later have special tax rules. If you are, or will be, 70 ½ this year please contact CalPERS to request a "Required Minimum Distribution" packet.

Distributions made *before* the calendar year you attain age 70 ½ - The taxable portion of your refund, as an Eligible Rollover Distribution (ERD) is subject to mandatory 20% Federal tax withholding unless the taxable portion of the refund is rolled over into an IRA or other eligible defined contribution plan.

Rollovers – An Eligible Rollover Distribution (ERD) consists of the taxable portion of a refund of your contributions, including interest, due to a separation from all CalPERS-covered employment. You may avoid current taxation on the taxable amount of an ERD by rolling over that amount to an individual retirement arrangement (IRA) or another qualified employer retirement plan that accepts rollover contributions. Taxes will be reportable when you take the money out of the IRA or other qualified plan.

Early withdrawal penalty – If you are under age 59 ½ at the time of the distribution, any taxable portion not rolled over may be subject to an early withdrawal penalty tax of 10% federal and 2 ½ % state unless an exception applies, PLUS any income tax due on the distribution. There are some instances where an individual will be exempt from the early withdrawal penalty, such as:

- A lump sum distribution made to you because of your separation from service after attaining age 55 or after becoming disabled. CalPERS cannot verify that a lump sum distribution was made due to disability; therefore you should contact the IRS directly to apply for this exception.
- The 10% federal penalty tax will be waived when a lump sum distribution is made because of your separation from service as a safety member (as defined by the IRS) providing police protection, firefighting service or emergency medical service. The separation of service must have occurred during or after the calendar year in which you attained age 50.

For more information on these exceptions, please contact the Internal Revenue Service, the Franchise Tax Board, or your tax consultant.

California State Tax Withholding – If you elect to receive an in-hand distribution of your contributions, California state income tax withholding is optional. State tax, if withheld, is 2% of the taxable portion of the refund. If you elect a rollover, no state tax will be withheld.

Refund Election Form

888 CalPERS (or 888-225-7377) • TTY for Speech and Hearing Impaired: (916) 795-3240 • Fax (916) 795-3988

Section 1 — Member Information

Name must be the same as the name on your Social Security card.

Name (First Name, Middle Initial, Last Name) _____ Social Security Number _____

( ) Daytime Phone ( ) Evening Phone _____

Address _____

City _____ State _____ ZIP _____

If you wish to elect a refund, and **will not attain age 70 ½ in the calendar year in which the refund is issued**, please complete and sign this form in the presence of a notary public or CalPERS employee. You may not elect a refund if you have been or will be re-employed with another CalPERS covered employer, or if you are accepting a position with another California Public Retirement System.

Section 2 — In-Hand Distribution or Rollover

Please elect ***either*** an in-hand distribution or a rollover.

Important
For direct rollover financial institution information – Do not submit a transfer form that was prepared by your financial institution in lieu of this completed form.

☐ I elect to receive an "in hand" distribution of my CalPERS contributions and interest.

Federal Tax withholding

Federal income tax will be withheld at a mandatory rate of 20% of the taxable amount unless you elect to roll the amount into an IRA account.

State Tax Withholding

☐ Yes – I elect to have 2% of the taxable portion withheld for state income tax.

☐ No – Do not withhold state income tax.

Note: If you do not check one of the above choices, state tax withholding will automatically be deducted.

☐ I elect to receive a refund as a direct rollover of the taxable portion of my contributions and interest made payable to the following financial institution.

My rollover account is an ( ) IRA Account ( ) Other eligible rollover plan

Name of Financial Institution for IRA Account or Eligible Rollover Plan _____

Section 3 — Spouse/Registered Domestic Partner Signature

You must complete a ***Justification for Non Signature of Spouse or Registered Domestic Partner*** form if you are married or in a registered domestic partnership and your spouse or domestic partner is unable to sign this form.

If you are married or have a registered domestic partner: your spouse or registered domestic partner must also sign this form.

By signing this form, I acknowledge my spouse's/ registered domestic partner's request for a refund.

Signature _____ Date (mm/dd/yyyy) _____

If no spouse / registered domestic partner signature, check below if the following applies to you:

☐ I am not legally married or do not have a registered domestic partner.

Put your name and Social Security number at the top of every page.

Your Name _____ Social Security Number _____

Section 4

Refund Election Waiver of Rights Notarized Signature

As the member requesting a refund you must sign this form in the presence of a notary public or authorized representative of CalPERS.

Please read and sign the following waiver of rights statement. No refund will be processed without your signature.

I am aware of my service and disability retirement rights under CalPERS. I have read the description of my rights, and the benefit calculation formula and table, set forth in the CalPERS member booklet for my specific classification. Despite my knowledge of these facts, **I hereby waive all rights and understand that by requesting a refund, I am forfeiting all future retirement benefits, unless I am a vested member under the State Second Tier.**

☐ I elect to receive a refund of my retirement contributions and interest which will terminate my CalPERS membership.

In signing this form I understand this decision is irrevocable.

Member Signature _____ Date (mm/dd/yyyy) _____

State of California

County of _____

On _____ (Date (mm/dd/yyyy)) before me, _____ (Name & Title of Officer)

personally appeared _____,

personally known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under **penalty of perjury** under the laws of the State of California that the foregoing paragraph is true and correct.

Notary Seal

Witness my hand and official seal

Signature of Notary Public _____ Date (mm/dd/yyyy) _____

or authorized CalPERS representative's signature.

Representative's Signature _____ Position Title _____ Date (mm/dd/yyyy) _____

Mail to: **CalPERS Benefit Services Division** • P.O. Box 942711, Sacramento, California 94229-2711